Division of Health Improvement

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2258 | A. BUILDING: ______ B. WING ______ | C 05/23/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE WOODMARK AT UPTOWN | 7201 PROSPECT PLACE NE ALBUQUERQUE, NM 87110 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| A 000 | Initial Comments<br><br>The following deficiencies were cited as a result of a Full-Onsite/Complaint survey completed on 05/23/17 for the state requirements of 7 NMAC 8.2, Regulations for Assisted Living Facilities.<br><br>Complaint Intake NM#30222 was substantiated with deficiencies cited.<br><br> | A 000 | The following plan of correction is being submitted by The Woodmark at Uptown, as mandated by the New Mexico Department of Health. However, this response is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies. Rather, it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. | |
| A 008 | 7 NMAC 8.2.8 General Licensing Requirements<br><br>GENERAL LICENSING REQUIREMENTS:<br>A. Licensure is required. No person or entity shall establish, maintain or operate an assisted living facility without first obtaining a license.<br>B. Application for licensure. An initial or renewal application shall be made on the forms prescribed by and available from the licensing authority. The issuance of an application form is not a guarantee that the completed application will be accepted, or that the department will issue a license. Information provided by the facility and used by the licensing authority for the licensing process shall be accurate and truthful. The licensing authority will not issue a new license if the applicant has had a health facility license revoked or renewal denied or has surrendered a license under threat of revocation or denial of renewal. The licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of applicable rules found to be class A or class B deficiencies as defined in Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC or has been non-compliant with plans of correction. The licensing authority will not issue a license until the applicant has supplied all of the information that is required by this rule. Any facility that fails to | A 008 | A008<br>Corrective Action:<br>The community license has been updated and is current as of June 1st, 2017.<br>Identification:<br>All of the community has the potential for being affected by the deficient practice.<br>The community will submit application for new licensee per state requirement within 10 business days when there is a change in Executive Director.<br>Systematic Changes:<br>The Executive Director will be responsible for submitting application for new licensee per State requirements within 10 days when there is a change in Executive | |

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| A 008 | Continued From page 1<br>participate in good faith by falsifying information presented in the licensing process shall be denied licensure by the department. The following information shall be submitted to the licensing authority for approval:<br>(1) a letter of intent that includes the proposed physical address, the primary population of the facility and a summary of the proposed services; after the letter of intent has been received, an application packet including; the application form, fee schedule and the licensing rule will be issued to the applicant by the licensing authority;<br>(2) the completed and notarized application and the appropriate non-refundable fee(s);<br>(3) a program narrative identifying and detailing the geographic service area, the primary population including any special needs requirements, along with a full description of the services that the applicant proposes to provide including:<br>(a) a description of the characteristics of the proposed population of the facility;<br>(b) a description of the services and care that will be provided to the residents;<br>(c) a description of the anticipated professional services to be offered to the residents; and<br>(d) a description of the facility ' s relationship to other services and related programs in the service area and how the applicant will collaborate with them to achieve a system of care for the residents.<br>(4) policies and procedures annotated to this rule;<br>(5) evidence to establish that the applicant has sufficient financial assets to permit operation of the facility for a period of six (6) months; the evidence shall include a credit report from one of the three recognized credit bureaus with a minimum credit score of six-hundred fifty (650) or above; | A 008 | Director. The Executive Director, Business Office Manager, or designee is responsible for completing this task.<br>Monitoring:<br>The Executive Director, Business Office Manager, or designee will be responsible for quarterly audit of community documents, to include licensure application. Review of audit results and corrective actions will be presented at quarterly Quarterly Assurance Meetings. | 6/1/17 |

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| A 008 | Continued From page 2<br>(6) copies of organizational documents to include the following list of items:<br>(a) the names of all persons or business entities that have at least five percent (5%) ownership interest in the facility, whether direct or indirect and whether in profits, land or building; this includes the owners of any business entity which owns all or part of the land or building;<br>(b) the identities of all creditors that hold a security interest in the premises, whether land or building;<br>(c) any changes in ownership or management shall be reported to the department within thirty (30) days;<br>(7) building plans as required at 7.8.2.41 NMAC of this rule;<br>(8) fire authority approval as required at 7.8.2.60 NMAC of this rule;<br>(9) a letter of approval or exemption from the local health authority having jurisdiction for the food service and the kitchen facility;<br>(10) a copy of liquid waste disposal and treatment system permit from local health authority having jurisdiction;<br>(11) approval from local zoning authority;<br>(12) building approval (certificate of occupancy); and<br>(13) any other information that the applicant wishes to provide or that the licensing authority may request.<br>C. Application for amended license. A licensee shall submit an application for an amended license and the required non-refundable fee to the licensing authority prior to a change with the facility. An amended license is required for a change of: location, administrator, facility name, capacity or any modification or addition to the building.<br>(1) An application for a change of the facility | A 008 | | |

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| A 008 | Continued From page 3<br>administrator or change of the administrator ' s name shall be submitted to the licensing authority within ten (10) business days of the change.<br>(2) An application for increase in capacity shall be accompanied by a building plan pursuant to 7.8.2.41 NMAC of this rule. A facility shall not increase census until the licensing authority has reviewed and approved the increase and has issued a new license that reflects the approved increase in capacity.<br>D. Application for license renewal. Each facility shall apply for a renewal of the annual license within thirty (30) business days prior to the license expiration date by submitting the following items:<br>(1) an application and the required fee;<br>(2) an updated program narrative, if the facility has changed the program or the focus of services;<br>(3) the annual fire inspection report; and<br>(4) the licensing authority may not issue a new license if the applicant has been cited repeatedly for violations of this rule or has been noncompliant with plans of correction or payment of civil monetary penalties.<br>E. License. Any person or entity that establishes, maintains or operates an assisted living facility shall obtain a license as required in this rule before accepting residents for care or providing services.<br>(1) Each facility that provides care or treatment shall obtain a separate license. The license is non-transferable and is only valid for the facility to which it is originally issued and for the owner or operator to whom it is issued. It shall not be sold, reassigned or transferred.<br>(2) The maximum capacity specified on the license shall not be exceeded.<br>(3) If the facility is closed and the residents are removed from the facility, the license shall be | A 008 | | |

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| A 008 | Continued From page 4<br>returned to the licensing authority. Written notification shall be issued to all residents or the residents ' surrogate decision maker and the licensing authority at least thirty (30) calendar days prior to the closure.<br>F. Temporary license.<br>(1) A temporary license may be issued to a new facility before residents are admitted provided that the facility has met all of the life safety code requirements as stated in this rule and policies and procedures for the facility have been reviewed and approved.<br>(2) Upon receipt of a temporary license, the facility may begin to admit up to three (3) residents.<br>(3) After the facility has admitted up to three (3) residents, the facility operator or owner shall request an initial health survey from the licensing authority.<br>(4) Following a determination of compliance with this rule by the licensing authority, an annual license will be issued. The renewal date of the annual license is based on the initial date of the first temporary license.<br>(5) The licensing authority has the right to determine compliance or noncompliance.<br>(6) A temporary license shall cover a period of time, not to exceed one hundred twenty (120) calendar days.<br>(7) No more than two (2) consecutive temporary licenses shall be issued. If a second temporary license is issued, an additional non-refundable fee is required. If all requirements are not met within the two hundred forty (240) day time frame, the applicant shall repeat the application process.<br>G. Annual license. An annual license is issued for one (1) year for a facility that has met all the requirements of this rule.<br>H. Display of license. The facility shall display the | A 008 | | |

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| A 008 | Continued From page 5<br>license in a conspicuous public place that is visible to residents, staff and visitors.<br>I. Unlicensed facilities. Any person or entity that opens or maintains an assisted living facility without a license is subject to the imposition of civil monetary penalties by the licensing authority. Failure to comply with the licensure requirements of this rule within ten (10) days of notice by the licensing authority may result in the following penalties pursuant to Health Facility Sanctions and Civil Monetary Penalties, 7.1.8 NMAC.<br>(1) A civil monetary penalty not to exceed five-thousand dollars ($5,000) per day.<br>(2) A base civil monetary penalty, plus a per-day civil monetary penalty, plus the doubling of penalties as applicable, that continues until the facility is in compliance with the licensing requirements in this rule.<br>(3) A cease and desist order to discontinue operation of a facility that is operating without a license.<br>(4) Additional criminal penalties may apply and shall be imposed as necessary.<br>[7.8.2.8 NMAC - Rp, 7.8.2.8 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.08 C (1)<br><br>Based on record review, observation, and interview, the facility failed to apply for an amended Assisted Living License within ten (10) business days of changing Administrators. This deficient practice has the potential for the 124 (R #s 1-124) residents identified on the resident census list, provided by the Business Office Manager on 05/18/17, to be at risk if the current Administrator has not met all the requirements of | A 008 | | |

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| A 008 | Continued From page 6<br><br>the Licensing Authority and is not qualified to provide oversight of their care and services. The findings are:<br><br>A. On 05/17/17 at 2:35 pm, during observation the facility's Assisted Living License revealed that it did not have the name of the current Administrator on it.<br><br>B. Record review of the Administrator's letter to the Licensing Authority dated 04/20/17 requesting an amended license revealed that it was not submitted within ten (10) days after she became the Administrator on 02/13/17.<br><br>C. On 05/19/17 at 10:22 am, during interview with the Administrator, she confirmed that the name on the posted Assisted Living License was not hers and that the application for an amended license was not submitted within ten (10) days after she began as the Administrator of the facility on 02/13/17. | A 008 | | |
| A 017 | 7 NMAC 8.2.17 Staff Training<br><br>STAFF TRAINING:<br>A. Training and orientation for each new employee and volunteer that provides direct care shall include a minimum of sixteen (16) hours of supervised training prior to providing unsupervised care for residents.<br>B. Documentation of orientation and subsequent trainings shall be kept in the personnel file at the facility.<br>C. Training shall be provided at orientation and at least twelve (12) hours annually, the orientation, training and proof of competency shall include:<br>(1) fire safety and evacuation training;<br>(2) first aid; | A 017 | A017<br><br>Corrective Action:<br>All current staff files have been audited to ensure completion of General Orientation. Any current staff are required to complete General Orientation by 10/15/17.<br>General Orientation revised to include required trainings for the State of New Mexico.<br>1. Fire Safety<br>2. First Aid<br>3. Safe Food Handling Practices (for persons involved in food preparation.) | |

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| A 017 | Continued From page 7<br>(3) safe food handling practices (for persons involved in food preparation), to include:<br>(a) instructions in proper storage;<br>(b) preparation and serving of food;<br>(c) safety in food handling;<br>(d) appropriate personal hygiene; and<br>(e) infectious and communicable disease control;<br>(4) confidentiality of records and resident information;<br>(5) infection control;<br>(6) resident rights;<br>(7) reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC;<br>(8) smoking policy for staff, residents and visitors;<br>(9) methods to provide quality resident care;<br>(10) emergency procedures;<br>(11) medication assistance, including the certificate of training for staff that assist with medication delivery; and<br>(12) the proper way to implement a resident ISP for staff that assist with ISPs.<br>D. If a facility provides transportation to residents, employees of the facility who drive vehicles and transport residents shall have training in transportation safety for the elderly and disabled, including safe vehicle operation.<br>[7.8.2.17 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.17 A B C (1) (2) (4) (5) (6) (7) (9) (10) (12)<br><br>Based on record review and interview, the facility failed to ensure for 9 (S #s 1-9) of 9 (S #s 1-9) Staff files reviewed for compliance had completed the required twelve (12) hours of orientation/annual training's and the information was documented/maintained in their personal | A 017 | 4. Confidentiality of records and resident information<br>5. Infection Control<br>6. Resident Rights<br>7. Reporting requirements for abuse, neglect, or exploitation<br>8. Smoking policy for staff, residents, or visitors<br>9. Methods to provide quality resident care<br>10. Emergency Procedures<br>11. Medication Assistance<br>12. Proper way to implement a resident ISP.<br>Business Office Manager has completed an audit of all staff records of required trainings.<br>HWD has completed Annual Inservice Calendar for 2017 and 2018.<br>Identification:<br>All current staff have the potential to be affected by the deficient practice.<br>The Executive Director, Business Office Manager, or designee will review all current employees by 10/15/17 to ensure correct documents are in place.<br>Systematic Changes:<br>All newly hired staff will receive General Orientation to include State required trainings prior to providing unsupervised care to the residents. | |

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| A 017 | Continued From page 8<br>files at the facility. This deficient practice has the potential for the safety and welfare of the residents to be at risk if the staff providing their care and services have not been properly trained and there is no documentation of the training's maintained in the staff files at the facility. The findings are:<br><br>A. Record review of the staff files for S# 1-9, revealed that the facility could not provide any documentation for review that would confirm that S #s 1-9 had completed any of the orientation/annual training for the following:<br>1. Fire safety and evacuation<br>2. First aid<br>3. Confidentiality of records and resident information.<br>4. Infection control.<br>5. Resident rights<br>6. Reporting requirements for abuse, neglect or exploitation in accordance with 7.1.13 NMAC.<br>7. Methods to provide quality resident care<br>8. Emergency procedures.<br>9. The proper way to implement a resident Individual Service Plan (ISP) for staff that assist with ISPs.<br><br>B. On 05/18/17 at 10:00 am, during interview with the Administrator and Business Office Manager, they confirmed there was no documentation maintained in staff files for S #s 1-9 that would confirm whether or not they had completed any of the twelve (12) hours of orientation/annual trainings listed above. They also stated that they did not know if S #s 1-9 had completed any of the training's listed above. | A 017 | Staff will be provided at least 12 hours annual training which includes State required topics.<br>Monitoring:<br>The Executive Director, Business Office Manager, Department Director or designee will be responsible for ensuring that General Orientation is completed for new hires.<br>The Executive Director, Business Office Manager, Department Director, or designee will be responsible for ensuring that annual training is completed by staff members.<br>The Executive Director, Business Office Manager, or designee will be responsible for auditing new hire personnel records monthly to ensure completion of General Orientation.<br>The Executive Director, Business Office Manager, or designee will be responsible for auditing personnel records monthly to ensure completion of annual training.<br>Results of audits will be discussed at Quarterly QA committee meeting. | 10/15/17 |

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| A 018 | Continued From page 9 | A 018 | A018 | |
| A 018 | 7 NMAC 8.2.18 Policies<br><br>POLICIES: The facility shall have and implement written personnel policies for the following:<br>A. staff, private duty attendant and volunteer qualifications;<br>B. staff, private duty attendant and volunteer conduct;<br>C. staff, private duty attendant and volunteer training policies;<br>D. staff and private duty attendant and volunteer criminal history screening;<br>E. emergency procedures;<br>F. medication administration;<br>G. the retention and maintenance of current and past personnel records; and<br>H. facilities shall maintain records and files that reflect compliance with NM and federal employment rules.<br>[7.8.2.18 NMAC - Rp, 7.8.2.17 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.18 A B C D G<br><br>Based on record review and interview, the facility failed to have adequate written personnel policies that describe the qualifications, conduct, training policies and criminal history screening of staff, private duty attendants and volunteers. In addition, the facility failed to develop and implement a policy on the retention and maintenance of current and past personnel records. These deficient practices can cause harm to the all of the 124 (R #s 1-124) of (R #s 1-124) residents identified on the resident census | A 018 | Corrective Action:<br>The community will immediately re-organize and re-implement<br>written personnel policies for the following:<br>1. Staff, private duty attendant, and volunteer qualifications;<br>2. Staff, private duty attendant, and volunteer conduct;<br>3. Staff, private duty attendant, and volunteer training policies;<br>4. Staff, private duty attendant, and volunteer criminal history screening;<br>5. Emergency Procedures<br>6. Medication Administration<br>7. The Retention and Maintenance of current and past personnel records.<br>The Executive Director, Business Office Manager, or designee will review the above policies with Department Directors by 10/6/17.<br>At General Orientation newly hired staff will be trained on SLC Code of Conduct, Emergency Procedures, First Aid, Confidentiality, Proper way to implement an Individualized Service Plan, Methods to provide Quality Care and Medication Administration.<br>The Executive Director, Business Office | |

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| A 018 | Continued From page 10<br>list provided by the Business Office Manager (BOM) on 05/18/17 by not having trained and qualified staff, if there are no Polices and Procedures in place to direct staff. The findings are:<br><br>A. Record review of the facilities policies and procedure manual revealed that is was missing the following policies;<br>1. staff, private duty attendant and volunteer qualifications;<br>2. staff, private duty attendant and volunteer conduct;<br>3. staff, private duty attendant and volunteer training policies;<br>4. staff and private duty attendant and volunteer criminal history screening;<br>5. the retention and maintenance of current and past personnel records<br><br>B. On 05/18/17 at 11:00 am, during an interview with the Administrator and the (BOM), they confirmed that the policy and procedures manual has not been updated for several years, was disorganized, and it either did not contain the above mentioned policies and procedures or they could not be found. | A 018 | A018<br>The Executive Director, Business Office Manager, or designee will notify new residents, family or authorized representative of Policy & procedure, qualifications, conduct, criminal record checks, and training requirements of private duty attendants.<br>Executive Director, Business Office Manager or designee will notify all current family members, residents and authorized representatives of the above policies, procedures, conduct and qualifications of private duty attendants by 11/1/17.<br>Executive Director, Business Office Manager or designee will notify all current companies who are providing private duty services to residents at the community of our policies regarding qualifications, conduct, training, screening, emergency procedures and medication administration for private duty attendants by 11/1/17.<br>Programming Director or designee will review volunteer qualifications to ensure all current volunteers meet the expectations.<br>Program Director or designee will review the code of conduct, training policies, emergency procedures with any | |
| A 022 | 7 NMAC 8.2.22 Facility Reports, Records, Rules, Policies<br><br>FACILITY REPORTS, RECORDS, RULES, POLICIES AND PROCEDURES:<br>A. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority, residents, potential residents or their surrogate decision makers: | A 022 | | |

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| A 022 | Continued From page 11<br>(1) fire inspection report;<br>(2) zoning approval;<br>(3) building official approval (certificate of occupancy);<br>(4) a copy of the approved building plans;<br>(5) a copy of the most recent survey conducted by the licensing authority, to include adverse actions or appeals and complaints;<br>(6) for facilities with food establishments/kitchens that require a permit from the local health authority that has jurisdiction, a copy of the current inspection report in accordance with the applicable, municipal, or federal laws and regulations and pursuant to Subsection B of 7.6.2.8 NMAC, regarding kitchen and food management; if a facility is considered a licensed private home and not required to meet specific requirements by the local health authority, a copy of that determination must also be maintained;<br>(7) where necessary, a copy of the liquid waste disposal and treatment system permit from the local health authority that has jurisdiction;<br>(8) thirty (30) days of menus as planned, including snacks and thirty (30) days of menus as served, including snacks;<br>(9) record of monthly fire drills conducted at the facility and the fire safety evaluation system (FSES) rating, if applicable;<br>(10) written emergency plans, policies and procedures for medical emergencies, power failure, fire or natural disaster; plans shall include evacuation, persons to be notified, emergency equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies; plans shall also included a list of transportation resources that are immediately available to transport the residents to another location in an emergency; the emergency preparedness plan shall address two types of | A 022 | current community volunteers by 11/1/17.<br>Systematic Changes:<br>Executive Director, Business Office Manager, or designee will train Department Directors on above listed policies and procedures by 10/11/17.<br>Monitoring:<br>Executive Director, Business Office Manager, or designee will be responsible for monthly audit of community documents. Review of audits at quarterly QA meetings.<br>A022<br>Corrective Action:<br>Company Incident reporting policy and procedure revised as of 6/8/17.<br>A022 A<br>Community staff trained on updated community policy and procedure for Incident Reporting to the Licensing Authority by 9/15/17.<br>A022 D<br>Community Staff trained on written Emergency Plans by 9/15/17.<br>Community Emergency Plan, Policy and Procedures are available at Concierge Desk, Business Office Manager Office, Executive Director Office, Spa area, Monarch area, Wellness, Programming office, Dining, | 11/1/17 |

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| A 022 | Continued From page 12<br>emergencies:<br>(a) an emergency that affects just the facility; and<br>(b) a region/area wide emergency;<br>(11) a copy of this rule, Requirements for Assisted Living Facilities for Adults, 7.8.2 NMAC);<br>(12) for facilities with two or more residents (that are not related to the owner), a valid custodial drug permit issued by the NM board of pharmacy, that supervise administration and self-administration of medications or safeguards with regard to medications for the residents; and<br>(13) vaccination records for pets in the facility.<br>B. Reports and records. Each facility shall keep the following reports, records, policies and procedures on file at the facility and make them available for review upon request by the licensing authority:<br>(1) a copy of the facility license;<br>(2) employee personnel records, including an application for employment, training records and personnel actions:<br>(a) caregiver criminal history screening documentation pursuant to 7.1.9 NMAC;<br>(b) employee abuse registry documentation pursuant to 7.1.12 NMAC; and<br>(3) a copy of all waivers or variances granted by the licensing authority.<br>C. Rules. Prior to admission to a facility a prospective resident or his or her representative shall be given a copy of the facility rules. Each facility shall have written rules pertaining to resident ' s rights and shall include the following:<br>(1) resident use of tobacco and alcohol;<br>(2) resident use of facility telephone or personal cell phone;<br>(3) resident use of television, radio, stereo and cd;<br>(4) the use and safekeeping of residents ' personal property; | A 022 | Plant Operations Office, Health and Wellness Director Office.<br>Staff Training to review Emergency Procedures Manual scheduled for 11/7/17.<br>Newly hired staff trained about location of Emergency Procedures Manual at General Orientation.<br>Identification:<br>All Community staff and residents have the potential to be affected by the deficient practice.<br>ED, BOM or designee responsible for monthly audit of General Orientation completion.<br>Systematic Change:<br>A022 A,D<br>Newly hired staff will be trained on Policy and Procedure for Incident Reporting and Emergency Procedures at General Orientation.<br>Current staff will be trained on Incident reporting to the Licensing Authority and Emergency Procedures in annual training.<br>Monitoring:<br>Executive Director, Business Office Manager, or designee will be responsible for monthly audit of General Orientation completion, Annual training attendance and ongoing staff training. Review of audits quarterly at QA meeting. | 11/1/17 |

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| A 022 | Continued From page 13<br>(5) meal availability and times;<br>(6) resident use of common areas;<br>(7) accommodation of resident ' s pets; and<br>(8) resident use of electric blankets and appliances.<br>D. Policies and procedures. All facilities shall have written policies and procedures covering the following areas:<br>(1) actions to be taken in case of accidents or emergencies;<br>(2) policy and procedure for updating and consolidating the residents current physician or PCP orders, treatments and diet plans every six (6) months or when a significant change occurs, such as a hospital admission;<br>(3) policy for medication errors;<br>(4) method of staying informed when residents are away from the facility (e.g., sign-out sheets or other record indicating where the resident will be, cell phone contact, etc.);<br>(5) the handling of resident's funds, if the facility provides such services;<br>(6) reporting of incidents, including abuse, neglect and misappropriation of property, injuries of unknown cause, environmental hazards and law enforcement interventions in accordance with 7.1.13 NMAC;<br>(7) reporting and investigating internal complaints;<br>(8) reporting and investigating complaints to the incident management bureau;<br>(9) staff and resident fire and safety training;<br>(10) smoking policy for staff, residents and visitors;<br>(11) the facility's bed hold policy;<br>(12) admission agreement;<br>(13) admission records;<br>(14) resident records including maintenance and record retention if the facility closes; | A 022 | | |

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| A 022 | Continued From page 15<br>equipment, evacuation routes, refuge areas and the responsibilities of personnel during emergencies and a list of transportation resources immediately available to transport the residents to another location for an emergency that affects just the facility and/or a region/area wide emergency.<br><br>If the facility does not have policy and procedures for reporting incidents and submitting follow-up investigation reports to the Licensing Authority or emergency plans for power failure, fire, natural disasters then the safety and welfare of all 124 (R #s 1-124) residents listed on the resident census provided by the Business Office Manager on 05/18/17 is at risk if there is no oversite of the facility by the Licensing Authority to protect them from being abused, neglected, or exploited and from being harmed, injured, or death in case of a power outage, fire, or natural disaster. The findings are:<br><br>A. Record review of the facility's Incident Reporting Policy and Procedure revised 02/24/17, revealed no documentation of the facility's responsibility for the state requirements NMAC 7.1.13 for Reporting of Incidents:<br>1. To report all suspected incidents of abuse, neglect, exploitation, or medication errors within twenty four (24) hours or the next business day if a weekend or holiday to the Licensing Authority.<br>2. To submit a follow-up investigation report within five (5) days of discovery of the incident.<br><br>B. Record review of the facility's Policies and Procedures book revealed no documentation could be found for: emergency plans for power failure, fire or natural disaster, that include persons to be notified, emergency equipment, refuge areas, staff responsibilities, transportation | A 022 | | |

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| A 022 | Continued From page 14<br>(15) program narrative;<br>(16) resident's rights with regard to making health care decisions and the formulation of advance directives;<br>(17) personnel policies;<br>(18) identifying and safeguarding resident possessions;<br>(19) securing medical assistance if a resident's own physician is not available;<br>(20) staff training appropriate to staff responsibilities;<br>(21) staff training for employees who provide assistance to residents with boarding or alighting from motor vehicles and safe operation of motor vehicles to transport residents;<br>(22) witnessed destruction of unused, outdated or recalled medication by the facility administrator with the consulting pharmacist present; and<br>(23) mealtimes, daily snacks, menus, special diets, resident ' s personal preference for eating alone or in the dining room setting.<br>[7.8.2.22 NMAC - Rp, 7.8.2.23 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.22 A (10), D (6) (7) (8)<br><br>Based on record review and interview the facility failed to have policy and procedures for:<br>1. Incident reporting to the Licensing Authority for the state requirements NMAC 7.1.13 for Reporting of Incidents.<br>2. Written emergency plans in case of power failure, fire, or natural disasters that include evacuation, persons to be notified, emergency | A 022 | | |

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| A 022 | Continued From page 16<br><br>services to relocate residents to another location for emergencies that affect only the facility and region wide emergency.<br><br>C. On 05/23/17 at 11:30 am, during interview with the Administrator, she confirmed that the:<br>1. Facility's policy and procedures for incident reporting does not include the requirement to report all incidents of abuse, neglect, exploitation, and medication errors to the Licensing Authority within 24 hours or the next business day if a holiday or weekend or submitting a follow-up investigation report within 5 days of discovery of the the incident.<br>2. Facility's policy and procedures for emergency procedures for power failure, fire, or natural disasters could not be found in the policy and procedures book. She also acknowledged that the policy and procedures book was very disorganized making it difficult to find the required documents. | A 022 | | |
| A 025 | 7 NMAC 8.2.25 Resident Evaluation<br><br>RESIDENT EVALUATION:<br>A. A resident evaluation shall be completed by an appropriate staff member within fifteen (15) days prior to admission to determine the level of assistance that is needed and if the level of services required by the resident can be met by the facility.<br>B. The initial resident evaluation shall establish a baseline in the resident ' s functional status and thereafter assist with identifying resident changes. The resident evaluation shall be reviewed and updated at a minimum of every six (6) months or when there is a significant change in the resident ' s health status.<br>C. The resident ' s evaluation shall be | A 025 | A025<br><br>Corrective Action:<br>Health and Wellness Director will provide Licensed staff training regarding change of condition policy and procedure by 10/15/17.<br>HWD will provide Licensed staff training regarding assessment schedule expectation by 10/15/17.<br>Weekly resident review with Executive Director, Health and Wellness Director, Resident Care Coordinator and Memory Care Coordinator to ensure followup, oversight, | |

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| A 025 | Continued From page 17<br>documented on a resident evaluation form and at a minimum include the following abilities, behaviors or status:<br>(1) activities of daily living;<br>(2) cognitive abilities; reasoning and perception; the ability to articulate thoughts, memory function or impairment, etc;<br>(3) communication and hearing; ability to communicate needs and understand instructions, etc;<br>(4) vision;<br>(5) physical functioning and skeletal problems;<br>(6) incontinence of bowel/bladder;<br>(7) psychosocial well-being;<br>(8) mood and behavior;<br>(9) activity interests;<br>(10) diagnoses;<br>(11) health conditions;<br>(12) nutritional status;<br>(13) oral or dental status;<br>(14) skin conditions;<br>(15) medication use and level of assistance needed with medications;<br>(16) special treatments and procedures or special medical needs such as hospice; and<br>(17) safety needs/high risk behaviors; history of falls agitation, wandering, fire safety issues, etc.<br>D. The resident evaluation shall include a history and physical examination and an evaluation report by a physician or a physician extender within six (6) months of admission. A resident shall have a medical evaluation by a physician or a physician extender at least annually.<br>E. The resident evaluation shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or physician extender at the time the individual service plan is reviewed, at a minimum of every six (6) months or when a significant change in health status occurs. | A 025 | and review changes.<br>Identification:<br>All residents have the potential to be affected by the deficient practice.<br>All resident evaluations will be reviewed by the Health and Wellness Director, Resident Care Coordinator or Licensed Nurse by 10/13/17. Any necessary changes will be noted and addressed.<br>Systematic Change:<br>Licensed staff inservices on Change of Condition and Assessment Schedule Expectation by 10/15/17.<br>Quarterly Licensed Staff systems review meeting scheduled with Health and Wellness Director for updates, review and follow for next quarterly meeting.<br>Review quarterly at QA meeting.<br>Newly hired Licensed, Direct Care and Memory Care staff will be trained on Policy and Procedure for Change of Condition at orientation.<br>Newly hired Licensed, Direct Care and Memory Care staff will be trained on the Policy and Procedure for Assessment Schedule Expectation at orientation.<br>Monitoring:<br>The LN will be responsible for Weekly clinical audit to verify that Changes in Condition have been addressed. Any findings will be reported to Health and Wellness Director | |

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| A 025 | Continued From page 18<br>[7.8.2.25 NMAC - Rp, 7.8.2.25 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.25 B<br><br>Based on record review and interview the facility failed to ensure for 5 (R #s 1, 3, 4, 5 and 7) of 7 (R #s 1, 2, 3, 4, 5, 7 and 8) residents reviewed that their evaluations/assessments were updated when a change of condition (hospice admission, falls) occurred. This deficient practice has the potential for residents to not receive the increased level of care and services needed if the evaluations/assessments have not been updated to reflect their increased level of care. The findings are:<br><br>A. Record review of R #1's resident evaluation/assessment dated 02/21/17, revealed that the resident had "no history of falls (no falls in the last year)" and was not updated to reflect her change in condition for three (3) unwitnessed falls with injuries documented in her progress notes on 02/22/17, 04/02/17, and 05/01/17 which included a head wound that required stitches.<br><br>B. Record review of R #3's resident evaluation/assessment dated 12/05/16, revealed that it stated "no hospice services required" and had not been updated to reflect her change of condition and admission to hospice services on 02/21/17.<br><br>C. Record review of R #4's resident | A 025 | Resident Care Coordinator, Memory Care Coordinator or designee for review and follow up.<br>Health and Wellness Director, Resident Care Coordinator, Licensed Nurse or designee wil complete quarterly audit of 10% of resident charts.<br>Results of audits will be reviewed quarterly QA meeting. | 11/1/17 |

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| A 025 | Continued From page 19<br>evaluation/assessment dated 05/08/17, revealed that it stated "no hospice services required" and had not been updated to reflect her change of condition and admission to hospice services on 11/25/16.<br><br>D. Record review of R #5's resident evaluation/assessment dated 11/03/16, revealed it was not updated to reflect her:<br>1. Readmission to the facility on 03/30/17, after her 03/02/17 fall with injury, being unresponsive, requiring Emergency Medical Services (EMS) and being hospitalized (facility incident report dated 03/02/17).<br>2. Change in condition documented in her progress notes on 04/04/17 where R #5 was found to be very lethargic and "She is now a two-person transfer; major fall risk".<br><br>E. On 05/19/17 at 11:45 am, during interview with the Director of Memory Care, she confirmed that the evaluations/assessments for R #s 1 and 3-5 had not been updated to include documentation of them being a fall risk or of their admission to hospice services.<br><br>F. Record review of R #7's evaluation/assessment dated 08/26/16, revealed that it was not updated for a change of condition when R #7 had two unwitnessed falls; one with injury and one without noted on the facility's Incident/Occurrence reports dated 11/18/16 and 12/17/16.<br><br>E. On 05/23/17 at 10:35 am, during an interview with the Administrator, she confirmed that R #7's evaluation/assessment was not updated for a change in condition when R #7 had two unwitnessed falls as stated on the facility's | A 025 | | |

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| A 025 | Continued From page 20<br>Incident/Occurrence reports dated 11/18/16 and 12/17/16. | A 025 | | |
| A 026 | 7 NMAC 8.2.26 Individual Service Plan<br><br>INDIVIDUAL SERVICE PLAN (ISP): An ISP shall be developed and implemented within ten (10) calendar days of admission for each resident residing in the facility.<br>A. The ISP shall address those areas of need as identified in the resident evaluation and through staff observation.<br>(1) The ISP shall detail the services that are provided by the facility as well as the services to be provided by other agencies.<br>(2) The resident evaluation and the ISP shall be reviewed and if needed revised by a licensed practical nurse, registered nurse or a physician extender.<br>(3) The ISP shall be reviewed and or revised at a minimum of every six (6) months or when there is a significant change in the resident ' s health status.<br>B. The ISP shall include the following:<br>(1) a description of identified needs as noted in the resident evaluation;<br>(2) a written description of all services to be provided;<br>(3) who will provide the services;<br>(4) when or how often the services will be provided;<br>(5) how the services will be provided;<br>(6) where the services will be provided;<br>(7) expected goals and outcomes of the services;<br>(8) documentation of the facility ' s determination that it is able to meet the needs of the resident;<br>(9) the level of assistance that the resident will require with activities of daily living and with medications; | A 026 | A026<br>Corrective Action:<br>The Health and Wellness Director, Resident Care Coordinator, Licensed Nurse, and Memory Care Director is responsible to ensure the Individual Service Plan will include documentation of Coordination of Care with Hospice and other outside care providers.<br>Health and Wellness Director will provide Licensed staff training on the Documentation of Coordination of Care Docmentation policy and procedure by 10/16/17.<br><br>Weekly resident review with Executive Director, Health and Wellness Director, Resident Care Coordinator and Memory Care Coordinator to ensure oversight, review changes.<br>Individual service plans will be signed when reviewed by the Licensed Nurse or Health and Wellness Director.<br>Identification:<br>All community residents have the potential to be affected by this deficient practice. | |

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| A 026 | Continued From page 21<br>(10) a crisis prevention/intervention plan when indicated by diagnosis or behavior; and<br>(11) current orders for all medications, including those authorized for PRN usage.<br>[7.8.2.26 NMAC - Rp, 7.8.2.26 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.26 A<br>Based on record review and interview the facility failed to ensure for 6 (R #s 1, 3, 4, 5, 7 and 8) of 7 (R #s 1, 2, 3, 4, 5, 7 and 8) whose Individual Service Plans (ISPs) were reviewed for compliance included:<br>1. Documentation of coordination of care with the hospice provider.<br>2. Updates when a change of condition occurred (fall risk, hospitalization, 2-person transfer).<br>3. They were signed as reviewed by a nurse.<br><br>These deficient practices have the potential for residents to be injured and/or not receiving the additional individual care and services each resident needs if the ISPs are not updated and reviewed by the nurse for accuracy so the Direct Care Staff will know what care to provide and what care will be provided by the hospice provider. The findings are:<br><br>A. Record review of R #1's ISP dated 02/21/17, revealed that is has not been updated to reflect her change in condition for three (3) unwitnessed falls with injuries documented in her progress notes on 02/22/17, 04/02/17, and 05/01/17 which included a head wound that required stitches. It was also not signed as reviewed by a nurse. | A 026 | All resident's Individual Service Plans will be reviewed by Health and Wellness Director, Resident Care Coordinator or Licensed Nurse by 10/16/17. Any necessary updates will be noted and addressed.<br>Systematic Change:<br>Newly hired staff will be trained on Policy and Procedure for Individual Service Plans at General Orientation.<br>Current staff annual training includes Individual Service Plans.<br>Quarterly Licensed Staff systems review with Health and Wellness Director for updates, feedback and followup. Review at QA meeting quarterly.<br>Monitoring:<br>The Licensed Nurse will be responsible for weekly clinical audit to verify that Changes in Condition, Coordination of Care and Licensed Nurse signatures on Individual Service Plan are in place.<br>Any findings will be reported to the Health and Wellness Director or designee for review and followup.<br>Health and Wellness Director, Resident Care Coordinator, Licensed Nurse or designee will complete quarterly audit of 10% of resident charts to ensure accuracy. | 10/16/17 |

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| A 026 | Continued From page 22 | A 026 | | |

B. Record review of R #3's ISP dated 12/05/16, revealed no documentation of coordination of care with her hospice provider and was not signed as reviewed by a nurse.

C. Record review of R #4's ISP dated 05/08/17, revealed no documentation of coordination of care with her hospice provider and was not signed as reviewed by a nurse.

D. Record review of R #5's ISP dated 11/03/16, revealed it was not updated to reflect her:
1. Readmission to the facility on 03/30/17; after her 03/02/17-fall with injury, being unresponsive, requiring Emergency Medical Services (EMS) and being hospitalized (facility incident report dated 03/02/17).
2. Change in condition documented in her progress notes on 04/04/17 where the R #5 was found to be very lethargic and "She is now a two-person transfer; major fall risk."
3. ISP was not signed as reviewed by a nurse.

E. On 05/19/17 at 11:45 am, during interview with the Director of Memory Care (DMC), she confirmed that the ISP's for R #s 3 and 4 did not include documentation of coordination of care with their hospice providers and were not signed as reviewed by a nurse.

F. On 05/23/17 at 9:13 am, during interview with the DMC, she confirmed that the ISP's for R #1 was not updated to reflect her change in condition (fall risk) and was not signed as reviewed by a nurse.

G. On 05/23/17 at 11:05 am, during interview with Registered Nurse (RN #1) she confirmed that the

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| A 026 | Continued From page 23<br>ISP for R #5 was not updated to reflect her change in condition (fall risk, hospitalization, 2-person transfer) and was not signed as reviewed by a nurse.<br><br>H. Record review of R #7's ISP dated 08/26/16, revealed that the ISP was not updated for a change in condition when R #7 had two unwitnessed falls on 11/18/16, and 12/16/16 reported on the facility's Incident/Occurrence reports dated 11/18/16 and 12/17/16.<br><br>I. On 05/23/17 at 10:35 am during an interview with the Administrator, she confirmed that R #7's ISP was not up-dated for a change in condition when R #7 had two unwitnessed falls on 11/18/16 and 12/16/16 as stated on the facility's Incident/Occurrence reports dated 11/18/16 and 12/17/16.<br><br>J. Record review of R #8's ISP dated 04/20/17 revealed it was not signed as reviewed by a nurse.<br><br>K. On 05/23/17 at 12:27 pm, during interview with RN #1, she confirmed that the ISP for R #8 was not signed as reviewed by a nurse. | A 026 | | |
| A 031 | 7 NMAC 8.2.31 Handling of Emergencies<br><br>HANDLING OF EMERGENCIES:<br>A. Upon admission, each resident or surrogate decision maker shall designate a primary care practitioner (PCP) to be called in case of a medical necessity. Each resident or representative shall also designate a concerned person to be called in case of an emergency. The facility shall establish a policy to secure medical assistance if the resident's own physician is not | A 031 | A031<br>Corrective Action:<br>Incident reporting Policy and Procedure revised 6/8/17. Community staff trained on updated Policy and Procedure for Incident Reporting to the Resident's Primary Care Physician and Authorized Representative completed by 9/15/17. | |

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| A 031 | Continued From page 24<br>available. In the event of an illness or an injury to the resident, the PCP or a physician extender shall be notified by the facility.<br>B. The facility shall have a first aid kit that contains at a minimum, gauze, adhesive tape, antiseptic ointment and bandages for emergencies. The first aid kit shall be kept in a designated, easily accessible place within the facility.<br>C. An easily accessible and functional telephone shall be available in each facility for summoning help in case of an emergency. A pay telephone does not fulfill this requirement.<br>D. A list of emergency numbers including: fire department, police department, ambulance services and poison control shall be posted near each public telephone in the facility.<br>[7.8.2.31 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.2.8.31 A<br><br>Based on record review and interview the facility failed to ensure that a primary care physician (PCP) and a designated person was contacted for a medical emergency. This deficient practice has the potential for all 124 (R #s 1-124) residents listed on the resident census list provided by the Business Office Manager on 05/18/17 to be at risk of being in pain, harm or death, if necessary life saving medical attention is delayed. The findings are:<br><br>A. Record review of the facility's Physician Incident Notification report dated 05/18/17 for | A 031 | Health and Wellness Director will provide Licensed staff training regarding Policy regarding Policy and Procedure for Reporting to the Resident's Primary Care Physician and Authorized Representative by 10/16/17.<br>Newly hired Licensed, Direct Care and Memory Care staff will be trained on the Policy and Procedure for Reporting to the Resident's Primary Care Physician and Authorized Representative in orientation.<br>Weekly resident review with Executive Director, Health and Wellness Director, Resident Care Coordinator and Memory Care Director to ensure oversight, follow up and review ongoing changes.<br>Identification:<br>All residents have the potential to be affected by the deficient practice.<br>Health and Wellness Director, Resident Care Coordinator, Licensed Nurse, Memory Care Director or designee is responsible to review Incidents daily to ensure proper notifications and follow up is provided.<br>Licensed Nurse, Resident Care Coordinator, Memory Care Coordinator | |

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| A 031 | Continued From page 25<br>R #1, revealed that her PCP was not informed of her unwitnessed fall with injuries (cut to the back of her head requiring stitches and bruising to her arms, elbow, thighs, and knees on 05/01/17 until 05/18/17, 17 days after the incident occurred.<br><br>B. On 05/22/17 at 2:15 pm, during interview with Registered Nurse (RN) #1, she confirmed that R #1's PCP was not informed of her unwitnessed fall with injuries (cut to the back of her head requiring stitches and bruising to her arms, elbow, thighs, and knees) until 05/18/17, 17 days after the incident occurred.<br>7.8.2.31 A<br><br>C. Record review of R #7's Assisted Living & Memory Care Incident/Occurrence report dated 12/16/16 completed by Medication Aide (MA) #1 revealed, that the medical emergency (R #7's Fall) was not reported to the PCP or the authorized representative until the following day. The unwitnessed fall took place at approximately 5:00 pm on 12/16/17. The authorize representative agency: [name of agency] were notified on 12/17/16 at 8:00 am and [name of physician] was notified on 12/17/16 at 11:00 am.<br><br>D. Record review of facility's Physician Incident Notification Document dated 12/17/16, revealed, that MA #1 contacted [name of physician] on 12/17/16 to inform of R #7's fall and that the incident took place the day before on 12/16/16.<br><br>E. Record review of R #7's December, 2016 MAR, revealed, that resident was taking prescription Coumadin/Warfarin (blood thiners) during the time of the incident.<br><br>F. Record review of facility's Policies and Procedures for Emergency Procedures last | A 031 | or designee will audit past 3 months Incidents to ensure proper notifications occurred and make notifications if necessary.<br>Systematic Changes:<br>Health and Wellness Director will train Licensed staff on Incident reporting and Emergency Procedures by 10/16/17.<br>Newly hired Licensed, Direct Care and Memory Care Staff will be trained on Policy and Procedure for Incident Reporting and Emergency Procedures at orientation.<br>Monitoring:<br>The Licensed Nurse will be responsible for weekly clinical audit to verify that notifications are made. Any findings will be reported to Health and Wellness Director, Resident Care Coordinator, Memory Care Director or designee for review and follow up.<br>Health and Wellness Director, Resident Care Coordinator, Licensed Nurse or designee will complete quarterly audit of 10% of resident charts to ensure appropriate notifications are made.<br>Results of audits will be reivewed at quarterly QA meeting. | 10/16/17 |

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| A 031 | Continued From page 26<br>revised on 06/04/15 revealed, the document states "In the event of a resident emergency situation such as, but not limited to, an un-witnessed fall where the resident is taking any of the following medications: Coumadin the procedures are to call 911, call the resident's physician, and notify resident's family or responsible party.<br><br>G. On 05/23/17 at 10:35 am, during an interview with the Administrator, she confirmed that R #7's emergency incident (unwitnessed fall) that occurred on 12/16/16 was not reported to the PCP or authorized representative on the day of 12/16/16, and that the facility's policy for emergency situations does state when a resident is on Coumadin that 911, resident's physician, and family or responsible party will be called, did not occur. | A 031 | | |
| A 032 | 7 NMAC 8.2.32 Reporting of Incidents<br><br>REPORTING OF INCIDENTS:<br>A. The facility shall insure that all suspected cases or known incidents of resident abuse, neglect or exploitation are reported in accordance with 7.1.13 NMAC.<br>(1) The facility shall also report any incident or unusual occurrence which has or could threaten the health, safety, or welfare of the residents and staff to the licensing authority complaint hotline within twenty-four (24) hours or by the next business day, if it is a weekend or a holiday.<br>(2) The facility shall not delay a report to the complaint hotline while an internal investigation is conducted.<br>B. The facility is responsible for conducting and documenting the investigation of all incidents within five (5) business days and shall submit a | A 032 | A032<br>Corrective Action:<br>Company Incident Reporting Policy and Procedure revised 6/8/17. Community staff trained on updated Policy and Procedure for Incident Reporting to the State Licensing Authority completed by 9/15/17.<br>Health and Wellness Director will provide Licensed staff training on Emergency Procedures and Incident Policy and Procedure by 10/16/17.<br>Weekly resident review with Executive Director, Health and Wellness Director Resident Care Coordinator | |

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| A 032 | Continued From page 27<br>copy of the investigation report to the licensing authority. A copy of the report and the documentation, including the date and time that it was submitted to the licensing authority, shall be maintained on file at the facility. The investigation shall include the following:<br>(1) a narrative description of the incident;<br>(2) the result of the facility's investigation shall be recorded on the state approved incident report form for the current year, pursuant to 7.1.13 NMAC; and<br>(3) plans for further actions in response to the incident.<br>[7.8.2.32 NMAC - Rp, 7.8.2.32 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.32 A (1)<br><br>.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS<br><br>Refer to 7.1.13.7 W. & 8 B. (2)<br><br>W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation.<br><br>B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents | A 032 | and Memory Care Director to ensure follow up, oversight and monitor changes. Staff training scheduled for 10/17/17 to review Policy and Procedure for Incident Reporting to the State Licensing Authority.<br>Identification:<br>All residents have the potential to be affected by the deficient practice.<br>Health and Wellness Director, Resident Care Coordinator, LIcensed Nurse Memory Care Director, or designee is responsible to review Incidents daily to ensure proper notification made to State Licensing Authority.<br>Licensed Nurse, Resident Care Coordinator, Memory Care Director or designee audit past 3 months Incidents to ensure proper notifications occurred and make the notifications if needed.<br>Systematic Change:<br>Current staff inserviced on Incident reporting and Emergency Procedures and notification of State LIcensing Authority by 9/15/17.<br>Newly hired Licensed, Direct Care and Memory Care Staff will be trained on Policy and Procedure for Incident Reporting and Emergency Procedures at General Orientation.<br>Current Staff training scheduled on | |

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| A 032 | Continued From page 28<br>utilizing the division's incident report form consistent with the requirements of the division's incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form<br><br>Based on record review and interview, the facility failed to ensure for 4 (R #s 1, 5, 7 and 9) of 5 (R #s 1, 2, 5, 7, and 9) residents whose internal incident reports were reviewed for compliance were reported to the Licensing Authority within twenty-four (24) hours or by the next business day if it is a weekend or a holiday. If the facility is not reporting incidents to the Licensing Authority then there would be no oversite to protect the residents from being abused, neglected, and/or injured. The findings are:<br><br>Findings related to R #1<br>A. Record review of the facility's Incident Report Book revealed no documentation that R #1's unwitnessed fall with injuries to her head (requiring stitches), bruises to her arms and thighs on 05/01/17 was reported to the Licensing Authority.<br><br>B. On 05/22/17 at 3:11 pm, during interview with Registered Nurse (RN #1), she confirmed that the | A 032 | Policy and Procedure for Proper Notification to Licensing Authority on 10/17/17.<br>Monitoring:<br>The Licensed Nurse will be responsible for weekly clinical audit to verify that notifications are made. Any findings will be reported to Health and Wellness Director or designee for review and follow up.<br>Health and Wellness Director, Resident Care Coordinator, Licensed Nurse or designee will complete quarterly audit of 10% of resident charts to ensure proper notification.<br>Results of audits will be shared at QA meetings quarterly. | 10/17/17 |

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facility did not report R #1's unwitnessed fall with injuries to the Licensing Authority. She further stated that to her knowledge in the 4-1/2 years she has been at the facility they have never reported falls to the Licensing Authority.

Findings related to R #5

C. Record review of the nurses note for R #5 dated 03/03/17, revealed that R #5 was sitting on the toilet and fell face first, while the Direct Care Staff (DCS) had turned to retrieve the resident's clothing from the bed, the DCS was not able to get back in time to catch her. R #5 was unconscious for a time and required Emergency Medical Services (EMS). R #5's Electrocardiogram (EKG) (heart monitoring test) revealed a heart anomaly (unusual) and she was taken to the Emergency Room (ER).

D. Record review of the facility incident report for R #5 dated 03/03/17, that there was no documentation that R #5's fall, being unconscious, and requiring Emergency Medical Services (EMS), then being transported/admitted to the hospital was reported to the Licensing Authority.

E. On 05/22/17 at 11:05 am, during interview with RN #1, she confirmed that R #5's fall with injuries/unconsciousness requiring EMS services and hospitalization was not reported to the state. R #1 stated that in the 4 1/2 years she has been working at the facility she has only seen the State Incident Report form used once and that was since the current Administrator arrived.

Findings for R #9

E. Record review of the facility's incident report

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| A 032 | Continued From page 30<br><br>for R #9 dated 04/09/17, revealed that she was given R #11's medications (including medication for hypertension/High Blood Pressure) after she was given her own medications. There is no documentation on the report that the medication error which had the potential for harm was reported to the Licensing Authority.<br><br>F. On 05/23/17 at 8:48 am, during interview with the Director of Memory Care (DMC), she confirmed that the medication error for R #9 was not reported to the Licensing Authority and stated she was not aware that medication errors had to be reported.<br><br>Findings related to R #7<br><br>G. Record review of R #7's Assisted Living & Memory Care Incident/Occurrence report dated 12/16/16 completed by Medication Aide (MA #1) revealed, that the resident had an unwitnessed fall and was complaining of a pain in left wrist, was not reported to the Licensing Authority.<br><br>H. On 05/23/17 at 10:35 am during an interview with the Administrator, she confirmed that R #7's unwitnessed fall on 12/16/16, where resident was complaining of pain in left wrist, was not reported to the Licensing Authority.<br><br>I. On 05/23/17 at 11:30 am, during interview with the Administrator, she confirmed that the reportable incidents for R #s 1, 5, 7, and 9 were not reported the Licensing Authority within 24 hours or the next business day if a weekend or holiday. | A 032 | | |

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| A 033 | Continued From page 31 | A 033 | | |
| A 033 | 7 NMAC 8.2.33 Resident Rights<br><br>RESIDENT RIGHTS: All licensed facilities shall understand, protect and respect the rights of all residents.<br>A. Prior to admission to a facility, a resident and legal representative shall be given a written description of the legal rights of the resident, translated into another language, if necessary, to meet the resident ' s understanding.<br>B. If the resident has no legal representative and is incapable of understanding his or her legal rights, a written copy of the resident's legal rights shall be provided to the most significant responsible party in the following order:<br>(1) the resident's spouse;<br>(2) significant other;<br>(3) any of the resident's adult children;<br>(4) the resident's parents;<br>(5) any relative the resident has lived with for six or more months before admission;<br>(6) a person who has been caring for, or paying benefits on behalf of the resident;<br>(7) a placing agency;<br>(8) resident advocate; or<br>(9) the ombudsman.<br>C. The resident rights shall be posted in a conspicuous public place in the facility and shall include the telephone numbers for the incident management hotline and for the state ombudsman program.<br>D. To protect resident rights, the facility shall:<br>(1) treat all residents with courtesy, respect, dignity and compassion;<br>(2) not discriminate in admission or services based on gender, sexual orientation, resident's age, race, religion, physical or mental disability, or nationality;<br>(3) provide residents written information about all | A 033 | A033<br>Corrective Action:<br>Company Incident Reporting Policy and Procedure revised 6/8/17. Community staff trained on updated Policy and Procedure for Incident Reporting to the Primary Care Physician as of 9/15/17.<br>Health and Wellness Director will provide Licensed staff training regarding the Emergency Procedures and Incident Reporting Policy and Procedure by 10/16/17.<br>Weekly resident review with Executive Director, Health and Wellness Director, Resident Care Coordinator and Memory Care Director to ensure oversight, and review ongoing changes.<br>Identification:<br>All residents have the potential to be affected by this deficient practice.<br>Health and Wellness Director, Resident Care Coordinator, Licensed Nurse, Memory Care Director or designee is responsible to review Incidents daily to ensure proper notification is made to Primary Care Physician.<br>Licensed Nurse, Resident Care Coordinator, Memory Care Director or designee will audit past 3 months incidents to | |

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| A 033 | Continued From page 32<br>services provided by the facility and their costs and give advance written notice of any changes;<br>(4) provide residents with a safe and sanitary living environment;<br>(5) provide humane care for all residents;<br>(6) provide the right to privacy, including privacy during medical examinations, consultations and treatment;<br>(7) protect the confidentiality of the resident ' s medical record;<br>(8) protect the right to personal privacy, including privacy in personal hygiene; privacy during visits with a spouse, family member or other visitor; and privacy in the resident's own room;<br>(9) protect the right to communicate privately and freely with any person, including private telephone conversations and private correspondence; and the right to receive visits from family, friends, lawyers, ombudsmen and community organizations;<br>(10) prohibit the use of any and all physical and chemical restraints;<br>(11) ensure that residents:<br>(a) are free from physical and emotional abuse neglect and misappropriation/or exploitation;<br>(b) are free from financial abuse and misappropriation by facility staff or management;<br>(c) are free to participate in religious, social, community and other activities and freely associate with persons in and out of the facility;<br>(d) are free to leave the facility and return without unreasonable restriction;<br>(e) are given a fifteen (15) calendar day, written notice before room transfers or discharge from the facility unless there is immediate danger to self or others in the facility;<br>(f) have an environment that fosters social interaction and avoids social isolation;<br>(g) or their surrogate decision makers, are | A 033 | ensure proper notifications occur and to make notifications if needed.<br>Systematic Change:<br>Licensed staff inserviced on Incident Reporting and Emergency Procedures by 9/15/17.<br>Newly hired LIcensed, Direct Care, Memory Care staff will be trained on Policy and Procedures for Incident Reporting and Emergency Procedures at General Orientation.<br>Current staff scheduled to be trained on Policy and Procedures for proper notification on 10/17/17.<br>Monitoring:<br>The Licensed Nurse will be responsible for weekly clinical audit to verify that proper notifications are made.<br>Any findings will be reported to Health and Wellness Director or designee for review and follow up.<br>Health and Wellness Director, Resident Care Coordinator, Licensed Nurse or designee will complete Quarterly audit of 10% of resident charts to ensure accuracy.<br>Results of audits will be shared at quarterly QA meetings. | |

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| A 033 | Continued From page 33<br>informed of and consent to the services provided by the facility;<br>(h) have the right to voice grievances to the facility staff, public officials, the ombudsmen, any state agency, or any other person, without fear of reprisal or retaliation;<br>(i) have the right to have their complaints addressed within fourteen (14) calendar days or sooner;<br>(j) have the right to participate in the development of their care plan/ISP;<br>(k) have the right to choose a doctor, pharmacist and other health care provider(s);<br>(l) have the right to participate in medical treatment decisions and formulate advance directives such as living wills and powers of attorney;<br>(m) have the right to keep and use personal possessions without loss or damage;<br>(n) have the right to manage and control their personal finances;<br>(o) have the right to freely organize and participate in a resident association that may recommend changes in the facility's policies, services and management;<br>(p) shall not be required to work for the facility; and<br>(q) are protected from unjustified room transfers or discharge.<br>E. The resident's rights shall not be restricted unless this restriction is for the health and safety of the resident, agreed to by the resident or the resident ' s surrogate decision maker and outlined in the resident ' s individual service plan.<br>[7.8.2.33 NMAC - Rp, 7.8.2.34 NMAC, 01/15/2010] | A 033 | | 10/17/17 |

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| A 033 | Continued From page 34<br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.33 D (5) (11) (a) (I)<br><br>Based on record review and interview the facility failed to ensure that a primary care physician (PCP) and a designated person was contacted for a medical emergency. This deficient practice has the potential for all 124 (R #s 1-124) residents identified on the resident census list provided by the Business Office Manager on 05/18/17 to be at risk of being in pain, harm or death, if necessary life saving medical attention is delayed. The findings are:<br><br>A. Record review of R #7's Assisted Living & Memory Care Incident/Occurrence report dated 12/16/16 completed by Direct Care Staff - Medication #1(DCS - M) revealed, that the medical emergency (R #7's Fall) was not reported to the PCP or the authorized representative until the following day. The unwitnessed fall took place at approximately 5:00 pm on 12/16/17. The authorize representiative agency: [name of agency] were notified on 12/17/16 at 8:00 am and [name of physician] was notified on 12/17/16 at 11:00 am.<br><br>B. Record review of the facility's Physician Incident Notification Document dated 12/17/16, revealed, that MA #1 contacted [name of physician] on 12/17/16 to inform of R #7's fall and that the incident took place the day before on 12/16/16.<br><br>C. Record review of R #7's December, 2016 MAR, revealed, that resident was taking prescription Coumadin/Warfrin (blood thiners) during the time of the incident. | A 033 | | |

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| A 033 | Continued From page 35<br><br>D. Record review of facility's Policies and Procedures for Emergency Procedures last revised on 06/04/15 revealed, the document states "In the event of a resident emergency situation such as, but not limited to, an un-witnessed fall where the resident is taking any of the following medications: coumadin the procedures are to call 911, call the resident's physician, and notify resident's family or responsible party.<br><br>E. On 05/23/17 at 10:35 am during an interview with the Administrator, she confirmed that R #7's emergency incident (fall) that occurred on 12/16/16 was not reported to the PCP or authorized representative on the day of 12/16/16, and that the facility's policy for emergency situations does state where a resident is on Coumadin that 911, resident's physician, and family or responsible party will be called, did not occur. | A 033 | | |
| A 034 | 7 NMAC 8.2.34 Custodial Drug Permits<br><br>CUSTODIAL DRUG PERMITS: A facility with two (2) or more residents that is licensed pursuant to this rule and that assists with self-administration or safeguards medications for residents shall have a current custodial drug permit issued by the state board of pharmacy.<br>A. Procurement, labeling and storage. The facility shall provide assistance to the resident in obtaining the necessary medications, treatment and medical supplies as identified in the ISP. The facility shall procure, label and store medications for residents who require assistance with self-administration of medication in compliance with state and federal laws.<br>(1) All medications, including non-prescription | A 034 | A034<br>Corrective Action:<br>On 7/1/17 a separate refrigerator with a lock has been provided for medications requiring refrigeration.<br>Daily temperature log initiated.<br>Direct Care Staff who assist with medication is responsible for temperature checks daily.<br>Identification:<br>All residents have the potential to be affected by this deficient practice. | |

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| A 034 | Continued From page 36<br>drugs, shall be stored in a locked compartment or in a locked room, as approved by the board of pharmacy and the key shall be in the care of the administrator or designee.<br>(2) Internal medication shall be kept separate from external medications. Drugs to be taken by mouth shall be separated from all other delivery forms.<br>(3) A separate, locked refrigerator shall be provided by the facility for medications. The refrigerator temperature shall be kept in compliance with the state board of pharmacy requirements for medications.<br>(4) All medications, including non-prescription medications, shall be stored in separate compartments for each resident and all medications shall be labeled with the resident's name.<br>(5) A resident may be permitted to keep his or her own medication in a locked compartment in his or her room for self-administration, if the physician's order deems it appropriate.<br>(6) The facility shall not require the residents to purchase medications from any particular pharmacy.<br>(7) Medical gases (oxygen) and equipment used for the administration of inhalation therapy and for resuscitative purposes shall comply with the national fire protection association (NFPA) 99.<br>(8) A proof of use record shall be maintained separately for each schedule II through IV drug (controlled substances). The proof of use sheet shall document:<br>(a) the type and strength of the schedule II through IV drugs;<br>(b) the date and time staff assisted with self-administration;<br>(c) the resident ' s name;<br>(d) the prescriber ' s name; | A 034 | Systematic change:<br>Daily medication room audit tool initiated to verify refrigerator lock is in place.<br>Monitoring:<br>Direct Care Staff will initial daily temperature / lock log to verify lock is in place. Licensed Nurse or designee will conduct monthly audit to verify placement of refrigerator lock. | 7/1/17 |

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| A 034 | Continued From page 37<br>(e) the dose;<br>(f) the signature of the person assisting with delivery of the medication; and<br>(g) the balance of medication remaining.<br>(9) Any remaining medication discontinued by a physician ' s order, or upon discharge or death of the resident shall be inventoried and moved to a separate locked storage container. Such discontinued medications shall be destroyed upon the next quarterly visit by the consulting pharmacist in accordance with 16.19.11.10 NMAC.<br>(10) The record of medication destruction shall be signed by the administrator or designee and the pharmacist and shall be kept on file at the facility.<br>B. Consulting pharmacist. The facility shall maintain records demonstrating that the consulting pharmacist provides the following oversight and guidance.<br>(1) Reviews the medication regimen as needed, but at least quarterly/every three (3) months, to determine that all medications and records are accurate and current. All irregularities shall be reported to the administrator of the facility and these irregularities shall be resolved by the administrator within seventy-two (72) hours.<br>(2) A system of records of receipt and disposition of all drugs in sufficient detail to enable an accurate reconciliation.<br>(3) Consultation shall be provided on all aspects of pharmacy services in the facility, including reference information regarding side effects and, when needed, physician consultation in cases involving the use of psychotropic medications.<br>(4) The consulting pharmacist will be responsible for assuring that the facility meets all requirements for storage, labeling, destruction and documentation of medications as required by | A 034 | | |

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| A 034 | Continued From page 38<br>the state board of pharmacy, 16.19.11.10 NMAC and 7.8.2 NMAC.<br>[7.8.2.34 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.34 A (3)<br><br>Based on observation, and interview, the facility failed to ensure that a lock was placed on the medication refrigerator used for medications requiring refrigeration. This deficient practice may have the potential for all 124 (R #'s 1-124) residents identified on the resident census list provided by the Business Office Manager on 05/18/17, to be at risk of illness, harm, or death if the medication refrigerator is opened by residents and any or all medications removed or ingested by residents. The findings are:<br><br>A. On 05/18/17 at 10:30 am, during observation in the assisted living wellness center the medication refrigerator was observed not to be locked.<br><br>B. On 05/18/17 at 10:35 am, during an interview with Registered Nurse (RN) #1, she confirmed that the refrigerator in the assisted living wellness center was not locked. | A 034 | A035<br>Corrective Action:<br>All current Licensed and Direct Care staff who assist with medications were trained on community Policy and Procedure regarding Blood Glucose Testing on 8/24/17.<br>All current Licensed and Direct Care staff who assist with medications will be trained on MAR compliance and recording on<br>1. The diagnosis/reason for taking the medication.<br>2. The brand/generic name of the medication.<br>3. Pre-medication information (blood sugar (CBG), blood pressure (BP), heart rate (HR) checks.<br>4. The initials and signatures of the Direct Care Staff (DCS) assisting with medication delivery.<br>5. Initials of the DCS staff are documented on the front of the MAR when resident medications are given.<br>6. Documentation of the desired results or problem encountered from missed, refused, or PRN (as needed medications). by 10/16/17. | |
| A 035 | 7 NMAC 8.2.35 Medication<br><br>MEDICATIONS: Administration of medications or staff assistance with self-administration of medications shall be in accordance with state and federal laws. No medications, including over-the-counter medications, PRN (when | A 035 | | |

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| A 035 | Continued From page 39<br>needed) medications, or treatment shall be started, changed or discontinued by the facility without an order from the physician, physician assistant or nurse practitioner and with entry into the resident's record.<br>A. State board of nursing licensed or certified health care professionals are responsible for the administration of medications. Administration may only be performed by these individuals.<br>B. Facility staff may assist a resident with the self-administration of medications if written consent by the resident is given to the administrator of the facility or the administrator ' s designee. If the resident is incapable of giving consent, the surrogate decision maker named in accordance with New Mexico law may give written consent for assistance with self-administration of medications. All staff that assist with self-administration of medications shall have successfully completed a state approved assistance with self-administration of medication training program or be licensed or certified by the state board of nursing.<br>C. PRN (pro re nada) medication.<br>(1) Physician or physician extender ' s orders for PRN medications shall clearly indicate the circumstances in which they are to be used, the number of doses that may be given in a 24-hour period and indicate under what circumstances the primary care practitioner (PCP) is to be notified.<br>(2) The utilization of PRN medications shall be reviewed routinely. Frequent or escalating use of PRN medications shall be reported to the PCP.<br>D. Only a licensed nurse (RN or LPN) shall administer any medications or conduct any invasive procedures provided by the following routes: intravenous (IV), subcutaneous (SQ), intramuscular (IM), vaginal or rectal. Only a licensed nurse shall administer non-premixed | A 035 | Direct Care Staff who assist with medications and Licensed staff will be trained at orientation on Blood Glucose Testing.<br>HWD, LN assessed all current residents who were being provided invasive procedures.<br>These assessments were completed 9/5/17.<br>Home Health and/or Community LN will provide support and/or assistance to resident with Blood Glucose Testing or invasive procedures.<br>HWD completed full MAR review in August 2017.<br>A035 D<br>HWD, RCC, LN notified and received orders to crush medications for current residents.<br>All current Licensed and Direct Care staff who assist with medications trained on Crushing Medications by 10/16/17.<br>Newly hired staff will review Policy and Procedure on Crushing Medications at Orientation.<br>HWD completed full MAR review in August 2017.<br>Scheduled Pharmacy | |

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| A 035 | Continued From page 40<br>nebulizer treatments.<br>E. The facility shall have medication reference material that contains information relating to drug interactions and side effects on the premises. Staff that assist in the self-administration of medications shall know interactions or possible side effects that might occur.<br>F. Medications prescribed for one resident shall not be used for another resident.<br>G. Medication assistance record (MAR). For residents who are not independent and require assistance with self administration, the facility shall have a MAR that documents the details of the residents' medication, including PRN and over-the-counter medication that is assisted with self-administration by qualified staff or administered to the resident by licensed or certified staff. The information in the MAR shall include:<br>(1) the resident's name;<br>(2) any known allergies to medication that the resident has;<br>(3) the name of the resident's PCP or the prescriber of the medication;<br>(4) the diagnosis or reason for the medication;<br>(5) the name of the medication, including the drug product brand name and the generic name;<br>(6) notation if the medication is a schedule II-IV drug;<br>(7) the dosage of the medication;<br>(8) the strength of the medication;<br>(9) the frequency or how often the medication is to be taken or given;<br>(10) the route of delivery for the medication (mouth, eye, ear, other);<br>(11) the method of delivery for the medication (pills, drops, IM injection, other);<br>(12) the date that the medication was started or discontinued; | A 035 | Consultant for full MAR review and Med cart check on 10/5/17.<br>A035G<br>All current Licensed and Direct Care staff who assist with medications trained on Documentation, Diagnosis, Reasons for Medications and Documenting on the MARs on 8/24/17.<br>Newly hired LN & direct care staff to review Policy / Procedure on Crushing Medications at orientation.<br>Identification:<br>All residents have the potential to be affected by the deficient practice.<br>HWD completed full MAR review in August 2017.<br>Scheduled Pharmacy Consultant for full MAR review and cart check on 10/5/17.<br>Systematic Change:<br>All current Licensed and Direct Care staff who assist with Medication trained on community Policy and Procedure regarding Blood Glucose Testing on 8/24/17.<br>Newly hired Licensed and Direct Care staff who assist with Medication will be trained at orientation on Blood Glucose Testing. All current Licensed and Direct Care staff who assist with Medication trained on Crushing Medications by 10/16/17. | |

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| A 035 | Continued From page 41<br>(13) any change in the medication order;<br>(14) pre-medication information (i.e., pulse, respiration, blood pressure, blood sugar) as required by the medication order;<br>(15) the date and time that the medication is self-administered, administered with assistance or is administered;<br>(16) the initials and signature of the person assisting with or administering the medication;<br>(17) the desired results obtained from or problems encountered with the medication (pain relieved, allergic reaction, etc.);<br>(18) any refused dose of medication;<br>(19) any missed dose of medication; and<br>(20) any medication error.<br>H. No medication shall be stopped or started without specific orders from the primary care physician.<br>I. If a resident refuses to take a prescribed medication, it shall be documented and the facility shall report it to the prescriber.<br>J. A suspected adverse reaction to a medication shall be documented on the MAR and reported immediately to the PCP and the resident's surrogate decision maker. If applicable, emergency medical treatment shall be arranged. Documentation of the event shall be kept in the resident's record.<br>K. Prescription medication, other than blister packs and unit dose containers, shall be kept in the original container with a pharmacy label that includes the following:<br>(1) the resident's name;<br>(2) the name of the medication;<br>(3) the date that the prescription was issued;<br>(4) the prescribed dosage and the instructions for administration of the medication; and<br>(5) the name and title of the prescriber.<br>L. Any medication that is removed from the | A 035 | Newly hired staff will review Policy and Procedure on Crushing Medications at Orientation.<br>All current Licensed and Direct Care Staff who assist with Medication trained on Documenting, Diagnosis,<br>Reasons for Medications and Documenting on the MARs on 8/24/17.<br>Newly hired staff will be trained on MAR documentation on:<br>1. The diagnosis/reason for taking the medication.<br>2. The brand/generic name of the medication.<br>3. Pre-medication information (blood sugar (CBG), blood pressure (BP), heart rate (HR) checks.<br>4. The initials and signatures of the Direct Care Staff (DCS) assisting with medication delivery.<br>5. Initials of the DCS are documented on the front of the MAR when resident medications are given.<br>6. Documentation of the desired results or problem encountered from missed, refused, or PRN (as needed) medications.<br><br>Newly hired staff will review Policy and Procedure on Crushing Medications at orientation.<br>LN or designee is completing monthly MAR audit to ensure items are completed. | 10/16/17 |

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| A 035 | Continued From page 42<br>pharmacy container or blister pack shall be given immediately and documented by the staff that assisted with the medication delivery.<br>M. The facility shall report all medication errors to the physician, documentation of medication errors and the prescriber's response shall be kept in the resident's record.<br>N. The facility shall develop and follow a written policy for unused, outdated, or recalled medications kept in the facility in accordance with 16.19.11.10 NMAC (AS AMENDED).<br>[7.8.2.35 NMAC - Rp, 7.8.2.35 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.35 A, D<br><br>Based on record review, observation, and interview the facility failed to ensure that:<br>1. Only a state licensed nurse or certified health care professionals conduct invasive procedures such as finger sticks for blood sugar checks and setting insulin pens to the number of units needed, for residents with diabetes who can not perform these tasks themselves.<br>2. Medications were not given or crushed without a physician's order.<br>These deficient practices have the potential for the 124 (R #s 1-124) residents listed on the resident census list, provided by the Business Office Manager on 05/18/17 to be at risk of illness injury, harm or death if:<br>1. Invasive procedures and/or the resident receives an incorrect dose of insulin, if performed by non-licensed direct care staff (DCS) who are not trained do these procedures. | A 035 | | |

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2. Residents are receiving medications or having medications crushed without a physician's order because the DCS are not trained to assess the residents need and provide treatment if residents receive incorrect medications and in the wrong form. The findings are:

Findings related to blood sugar checks/insulin:

A. Record review of R #1's 05/01/17 to 05/22/17 Medication Administration Record (MAR) revealed that her blood glucose is to be checked each morning and that she receives an insulin injection of 10 units each evening at 7:00 pm.

B. On 05/18/17 at 2:19 pm, during interview with the Direct Care Staff who assists with medication (DCS-M #3), she stated that R #1 has her blood glucose checked each morning at 6:30 am, and is unable to do her own finger sticks. DCS-M #3 confirmed that the DCS-Ms who are not nurses do R #1's finger sticks each morning. DCS-M #3 stated that the resident is unable to set her injection pen to the correct number of units and confirmed that the DCS-Ms set the pen to 10 units for R #1.

C. On 05/19/17 at 9:45 am, during interview with DCS-M #4, she confirmed that R #1 is unable to do her own finger sticks and/or set her injection pen to the correct number of units and that the DCS-Ms do these tasks for her.

D. On 05/23/17 at 2:30 pm, during interview with the Administrator and RN #1, they confirmed that R #1 is unable to do her own blood sugar checks and set her insulin pen to the correct number of units. They acknowledged that the DCS-M's who have been doing these tasks for R #1 are not licensed nurses of certified health care

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professionals.

Findings related to physician orders:

E. On 05/19/17 at 8:23 am, during observation of the medication pass for R #3, (DCS-M #1) was observed crushing her medication and mixing it with yogurt. DCS-M #1 confirmed that he crushed R #3's medication and mixed it with yogurt.

F. Record review of R #3's 05/01/17 to 05/18/17 MAR and resident file, revealed no documentation of a physician's order for her medications to be crushed and put in food.

G. On 05/19/17 at 1:19 pm, during interview with DCS-M #2, she confirmed that there were no physician's orders for R #3 medications to be crushed and mixed with food.
Findings related to R #15:

H. Record review of R #15's resident file revealed medications listed on R #15's 05/01/17 - 05/22/17 MAR as follows:
1. Aspirin (reduce fever and relieve mild to moderate pain, prevent heart attacks/strokes) 81 mg tablet. Take one tablet by mouth everyday.
2. Atenolol (chest pain) 25 mg tablet. Take 1/2 tablet by mouth everyday
3. Losartan Potas (lowers high blood pressure) 100 mg tablet. Take one tablet by mouth everyday, that there were no Physician's orders for any of the above medications in resident's file.

I. On 05/23/17 at 9:15 am, during an interview with DCS-M #4, she confirmed that R #15's orders for Aspirin 81 mg tablet, Atenolol 25 mg tablet, and Losartan Potas 100 mg tablet were

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missing from R #15's file.

Findings related to R #6:

J. Record review of R #6's resident file, revealed medication listed on R #6's 05/01/17 - 05/22/17 MAR for Melatonin (sleep aid) 3 mg, take one tablet by mouth every night at bed time, that there was no Physician's order for the medication in resident's file.

K. On 05/23/17 at 9:45 am, during an interview with DCS-M #6, she confirmed that R #6's order for Melatonin 3mg was not in R #6's file.

7.8.2.35 G (4) (5) (14) (16) (17) (19))

Based on record review and interview, the facility failed to ensure that for 6 (R #s 1-6) of 6 (R #s 1-6) residents whose Medication Administration Records (MARs) were reviewed for compliance included:

1. The diagnosis/reason for taking the medication,
2. The brand/generic name of the medication.
3. Pre-medication information (blood sugar (CBG), blood pressure (BP), heart rate (HR) checks.
4. The initials and signatures of the Direct Care Staff (DCS) assisting with medication delivery,
5. Initals of the DCS staff are documented on the front of the MAR when resident medications are given.
6. Documentation of the desired results or problem encountered from missed, refused, or PRN (as needed medications).

These widespread deficient practices have the

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| A 035 | Continued From page 46<br>potential for residents to be at risk of pain/suffering, illness, or harm, and required additional medical care if the DCS who assist with medications do not:<br>1. Know the diagnosis/reason for the medication.<br>2. Know the brand/generic name of the medication.<br>3. Complete the physician ordered pre-medication checks (CBG, BP, HR).<br>4. Sign their initials on the front of the MAR when resident medications are given/refused/missed.<br>5. Sign both their initials and signatures on each page of the MAR.<br>6. Document the desired results or problem encountered from missed, refused, or PRN (as needed medications). The findings are:<br><br>Findings for R #1<br><br>A. Record review of R #1's MAR's dated 05/01/17 to 05/22/17, revealed the following medications were missing the diagnosis/reason for the medication:<br>1. Vitamin D-3 (supplement).<br>2. Divalproex/Depakote (seizures/bi-polar/Alzheimers).<br>3. Calcitriol/Rocaltrol (calcium/vit-d supplement).<br>4. Lantus/Insulin (diabetes).<br>5. Memantime/Namenda (memory loss).<br>6. Aspirin/Ecotrin (heart).<br>7. Felodipine/Plendil (high blood pressure)<br>8. Terazosin/Hytrim (hypertension)<br><br>B. Record review of R #1's MAR's dated 05/01/17 to 05/22/17, revealed that both the brand and generic name for Januvia/Sitagliptin (diabetes) was listed on the MAR. | A 035 | At change of shift Direct Care staff who assist with medication are completing MAR audit sheet to ensure completion of MAR.<br>LN completing monthly MAR audit to ensure completion and follow up.<br>Results of audits to be discussed at quarterly QA meeting. | |

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C. Record review of R #1's MAR's dated 05/01/17 to 05/22/17 no documentation that the physician ordered morning blood sugar checks were done on 05/06/17, 05/13/17, 05/14/17, and 05/20/17.

D. Record review of R #1's MAR's dated 05/01/17 to 05/22/17 that there were no DCS initials to indicate that R #1 received the following medications:

1. 1 dose of Divalproex/Depakote (seizures/bi-polar/Alzheimers) on 05/08/17 at 5:00 pm.
2. 1 dose of Glipizide/Glucotrol (diabetes) on 05/08/17 at 8:00 pm.
3. 1 dose of Calcitriol/Rocaltrol (calcium/vit-d supplement) on 05/08/17 at 8:00 pm.
4. 2 doses of Lantus/Insulin (diabetes) on 05/08/17 and 05/13/17 at 8:00 pm.
5. 1 dose of Memantime/Namenda (memory loss) on 05/08/17 at 8:00 pm.

E. Record review of the back side of R #1's MAR's dated 05/01/17 to 05/22/17 revealed there was no documentation as to if/why R #1 did not received her medications on 05/08/17 and blood sugar checks on 05/06/17, 05/13/17, 05/14/17, and 05/20/17.

F. Record review of the back side of R #1's MAR's dated 05/01/17 to 05/22/17 revealed no DCS initials for 1 dose of MPAP/Tylenol (pain) on the front of the MAR on 05/12/17, that was noted as given on the back of the MAR.

Findings for R #2

G. Record review of R #2's MAR's dated 05/01/17 to 05/22/17 revealed that there was no

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diagnosis/reason for listed for Quetiapine/Seroquel (behavior disorders).

H. Record review of R #2's MAR's dated 05/01/17 to 05/22/17 revealed that there was not both the brand and generic name for the PRN (as needed) Seroquel/Quetiapine (behavior disorders) listed on the MAR.

I. Record review of R #2's MAR's dated 05/01/17 to 05/22/17 revealed that there was 1 PRN dose of Quetiapine/Seroquel (behavior disorders) was signed as given on 05/08/17 with no documentation the DCS of when/why/desired results medication was given.

Findings for R #3

J. Record review of R #3's MAR's dated 05/01/17 to 05/19/17, revealed the following medications were missing the diagnosis/reason for the medication:

1. Nectar Thick Liquids/liquid thickener powder (difficulty swallowing).
2. Aspirin/Ecotrin (heart).
3. Citalopram/Celexa (depression, memory loss).
4. Potassium liquid/Potassium chloride (supplement).
5. Salonpas patches (pain).
6. Vitamin B-12//V-R Vitamin B-12 (supplement).
7. Mighty Shakes (supplement).
8. Advair/Fluticasone Propionate (improve breathing).
9. Carvedilol/Coreg (high blood pressure/hypertension).
10. Lovastatin/Mevacor (high cholesterol).
11. Melatoni/Melatonin (sleep).
12. Acetaminophen/Tylenol (pain).

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K. Record review of R #3's MAR's dated 05/01/17 to 05/19/17, revealed that both the brand and generic names for the following medications were not listed on the MAR:
1. Advair/Fluticasone Propionate (improve breathing).
2. Acetaminophen/Tylenol (pain).
3. Ventolin/Albuterol inhalation (improve breathing).

L. Record review of R #3's MAR's dated 05/01/17 to 05/19/17, revealed that there were no DCS initials to indicate that R #3 received thickened liquids on 05/06/17, 05/14/17, and 05/15/17 on the 2:00 pm, to 10:00 pm shift.

M. Record review of the back side of R #3's MAR's dated 05/01/17 to 05/19/17 revealed there was no documentation as to if/why R #3 did not received her thickened liquids medications on 05/06/17, 05/14/17, and 05/15/17 on the 2:00 pm, to 10:00 pm shift.

Findings for R #4

N. Record review of R #4's MAR's dated 05/01/17 to 05/19/17, revealed the following medications were missing the diagnosis/reason for the medication:
1. Pantoprazole/Protonix (stomach acid relief).
2. Boost shakes (supplement).
3. Lisinopril/Prinivil (high blood pressure-hypertension).
4. Potassium Chloride/K-DUR (supplement).
5. Pravastatin Sodium/Pravachol (high cholesterol).
6. Ammonium Lactate/Amlactin (dry skin)

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O. Record review of R #4's MAR's dated 05/01/17 to 05/19/17, revealed that there were no DCS initials to indicate that R #4 received the following medications:
1. 2 doses of Pantoprazole/Protonix (stomach acid relief) on 05/06/17 and 05/12/17 at 8:00 pm.
2. 1 dose of Pravastatin Sodium/Pravachol (high cholesterol) on 05/12/17 at 8:00 pm.

P. Record review of the back side of R #4's MAR's dated 05/01/17 to 05/19/17 revealed there was no documentation as to if/why R #4 did not received the following medications:
1. 2 doses of Pantoprazole/Protonix (stomach acid relief) on 05/06/17 and 05/12/17 at 8:00 pm.
2. 1 dose of Pravastatin Sodium/Pravachol (high cholesterol) on 05/12/17 at 8:00 pm.

Q. Record review of R #4's MAR's dated 05/01/17 to 05/19/17, revealed it was missing the initials and signatures of DCS staff that assisted with medications.

Findings related to R #5.

R. Record review of R #5's MAR's dated 05/01/17 to 05/22/17 revealed the following medications were missing the diagnosis/reason for the medication:
1. Hydrocodone/Norco (pain).
2. Warfarin/Coumadin (blood thinner).
3. Preservision/Vitamin (eyes).
4. TED Hose/stockings (blood clots).
5. Mupirocin/Bactroban (skin infections).
6. Mucinex/Guaifenesin (cough-congestion).
7. Klor-Con/K-DUR (potassium supplement).
8. Hydrocortisone/Anusol cream (hemorrhoids).
9. Proventil/Albuterol (breathing)

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| A 035 | Continued From page 51<br>S. Record review of R #5's MAR's dated 05/01/17 to 05/22/17, revealed that both the brand and generic names for the following medications were not listed on the MAR.<br>1. Proventil/Albuterol (breathing)<br>2. Mucinex/Guaifenesin (cough-congestion).<br>3. Cranberry/multiple brand names (supplement)<br><br>T. Record review of R #5's MAR's dated 05/01/17 to 05/22/17, revealed that there were no DCS initials to indicate that R #5 received his dose of Hydrocodone/Norco 05/15/17 at 8:00 pm and there was no documentation on the back of the MAR to indicate if/why R #5 did not received the medication.<br><br>U. Record review of R #5's MAR's dated 05/01/17 to 05/22/17, revealed it was missing the initials and signatures of the DCS staff who assisted with medications.<br><br>Findings for R #6<br><br>V. Record review of R #6's MAR's dated 05/01/17 to 05/22/17 revealed the following medications were missing the diagnosis/reason for the medication:<br>1. MAPAP-Acetaminophen/Tylenol (pain),<br>2. Eliquis/Apixaban (blood thinner).<br>3. Gabapentin/Neurontin (pain).<br>4. Atorvastatin/Lipitor (high cholesterol)<br><br>W. Record review of R #6's MAR's dated 05/01/17 to 05/22/17 revealed that both the brand and generic names for the following medications were not listed on the MAR.<br>1. Tylenol/Acetaminophen (pain).<br>2. Amoxicillin/penicillin (antibiotic).<br>3. Eliquis/Apixaban (blood thinner). | A 035 | | |

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| A 035 | Continued From page 52 | A 035 | | |

4. Gabapentin/Neurontin (pain).
5. Imodium/Loperamide (constipation)

X. Record review of R #6's MAR's dated 05/01/17 to 05/22/17 revealed that on the following days the DCS who took R #6's physician ordered heart rate and blood pressure checks before taking Metoprolol/Lopressor (blood pressure) failed to document the readings:

a. 05/04/17 at 8:00 pm, (both HR and BP).
b. 05/14/17 at 8:00 pm, (both HR and BP).
c. 05/17/17 at 8:00 pm, (both HR and BP).
d. 05/21/17 at 8:00 pm, (both HR and BP).

Y. Record review of R #6's MAR's dated 05/01/17 to 05/22/17, that there were no DCS initials to indicate that R #6 received the following medications:

1. MAPAP/Tylenol (pain):
   a. 05/02/17 at 8:00 pm.
   b. 05/15/17 at 8:00 pm.
   c. 05/19/17 at 12 noon.
2. Diclofenac/Voltaren (pain) cream:
   a. 05/06/17 at 4:00 pm.
   b. 05/13/17 at 4:00 pm.
   c. 05/14/17 at 4:00 pm.
   d. 05/18/17 thru 05/21/17 at 12 noon.
   E. 05/19/17 AT 4:00 pm.
3. Celecoxis/Celebrex (pain): 05/02/17 R 8:00 PM.

Z. Record review of R #6's MAR's dated 05/01/17 to 05/22/17 revealed, revealed there was no documentation as to if/why R #6 did not received the following medications:

1. MAPAP/Tylenol (pain):

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| A 035 | Continued From page 53<br>a. 05/02/17 at 8:00 pm.<br>b. 05/15/17 at 8:00 pm.<br>c. 05/19/17 at 12 noon.<br>2.Diclofenac/Voltaren (pain) cream:<br>a. 05/06/17 at 4:00 pm.<br>b. 05/13/17 at 4:00 pm.<br>c. 05/14/17 at 4:00 pm.<br>d. 05/18/17 thru 05/21/17 at 12 noon.<br>E. 05/19/17 AT 4:00 pm.<br>3.Celecoxis/Celebrex (pain): 05/02/17 R 8:00 PM.<br>4. Metoprolol/Lopressor (blood pressure): 05/22/17 at her 8:00 am.<br><br>AA: Record review of R #6's MAR's dated 05/01/17 to 05/22/17 revealed, it was missing the initials and signatures of the DCS staff who assisted with medications.<br><br>BB. On 05/19/17 at 2:45 pm, during interview with the Administrator, she confirmed that the MARs for R #s 1-6 were missing following documentation:<br>1. The diagnosis/reason for taking the medication.<br>2. The brand/generic name of the medication.<br>3. Pre-medication information (blood sugar (CBG), blood pressure (BP), heart rate (HR) checks.<br>4. The initials and signatures of the Direct Care Staff (DCS) assisting with medication delivery,<br>5. Initals of the DCS staff are documented on the front of the MAR when resident medications are given.<br>6. Documentation of the desired results or problem encountered from missed, refused, or PRN (as needed medications). She could not confirm if the residents received any of the | A 035 | | |

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| A 035 | Continued From page 54<br>mediation doses that the DCS staff did not sign as given. | A 035 | | |
| A 042 | 7 NMAC 8.2.42 Maintenance of Building and Grounds<br><br>MAINTENANCE OF BUILDING AND GROUNDS: The building(s) shall be maintained in good repair at all times. Such maintenance shall include, but is not limited to, the following areas:<br>A. Storage areas/grounds. Storage areas and grounds shall be maintained in a safe, sanitary and presentable condition at all times. Storage areas and grounds shall be kept free from accumulation of refuse, weeds, discarded furniture, old newspapers or other items that create a fire hazard.<br>B. Floors. Floors shall be maintained stable, firm and free of tripping hazards.<br>[7.8.2.42 NMAC - Rp, 7.8.2.43 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.42 A B<br><br>Based on observation and interview, the facility failed to ensure the:<br>1. Mechanical/maintenance room (unlocked and accessible to residents) was kept free of tripping and fire hazards.<br>2. The call-light cords were wrapped around the call light units or grab bars preventing them from working and notifying staff when pulled.<br><br>These deficient practices can cause injury, harm, or death to the 124 (R #s 1-124) of (R #s 1-124) residents listed on the resident census list | A 042 | A042<br>Corrective Action:<br>All combustible items have been removed from the Mechanical/maintenance room by 9/7/17.<br>Rooms inspected by Direct Care staff and Housekeeping staff daily to ensure proper placement of call cords.<br>Executive Director and Plant Operations Director or designee<br>visually inspect mechanical room and storage areas weekly to ensure clean and clear of items.<br>Executive Director trained staff on Fire Safety 9/6/17.<br>All staff training for Call Cord Placement scheduled for 10/17/17.<br>Identification:<br>All staff and residents have the potential to be affected by the deficient practice.<br>Executive Director and Plant Operations Director or designee<br>visually inspect mechanical room and storage areas weekly to ensure clean and clear of items.<br>Housekeeping and Direct care staff check rooms daily for proper placement of call cords.<br>Review any areas noted at Safety Committee. | |

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| A 042 | Continued From page 55<br>provided by the Business Office Manager on 05/18/17, if combustible materials are not stored correctly and/or if the call-light system does not notify the DCS that a resident needs assistance. The findings are:<br><br>A. On 05/22/17 at 11:45 am, during observation of the mechanical /maintenance room, combustible materials were observed surrounding the facility's water heaters, electric panels, and sprinkler system, including; 12 oz tubes of calking, 5 gallon paint containers, cases of flooring materials and assorted boxes that create a fire and tripping hazard.<br><br>B. On 05/22/17 at 11:46 am, during interview with the Maintenance Director (MD), he confirmed the unsafe storage of the combustibles items in the mechanical room which creates a tripping and fire hazard.<br>Findings related to call-light system<br><br>C. On 05/18/17 at 1:50 pm, during an interview and observation of community bathroom in Memory Care Unit on second floor, the alarm cord was found to be wrapped around the hand rail. Medication Aide (MA) #7, confirmed the observation that the alarm cord was wrapped around the hand rail.<br><br>D. On 05/18/17 at 2:10 pm, during an observation of R #10's room and bathroom it was found that the alarm cord was wrapped around the hand rail in residents bath room.<br><br>E. On 05/18/17 at 2:15 pm, during an interview with Registered Nurse (RN) #2, she confirmed that the alarm cord was wrapped around the hand rail in R #10's bathroom. | A 042 | Systematic Change:<br>All current Housekeeping and Maintenance staff training on Safe Storage and Fire Hazards by 10/15/17.<br>Staff training on Call Cord Placement scheduled for 10/17/17.<br>Newly hired staff will be trained at General Orientation on Fire Hazards, Safe Storage and Proper Call Cord Placement.<br>Results of audits to be discussed at quarterly QA meetings. | 10/17/17 |

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| A 060 | Continued From page 56 | A 060 | A060 | |
| A 060 | 7 NMAC 8.2.60 Fire Clearence and Inspections<br><br>FIRE CLEARANCE AND INSPECTIONS:<br>A. Written documentation of a facility's compliance with applicable fire prevention codes shall be obtained from the state fire marshal ' s office or the fire prevention authority with jurisdiction and shall be submitted to the licensing authority prior to the issuance of an initial license.<br>B. The facility shall request an annual fire inspection from the local fire prevention authorities. If the policy of the local fire department does not provide an annual inspection of the facility, the facility will document the date the request was made and to whom and then contact licensing authorities. If the local fire prevention authorities do make annual inspections, a copy of the latest inspection must be kept on file in the facility.<br>[7.8.2.60 NMAC - Rp, 7.8.2.59 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.60 B<br><br>Based on record review and interview, the facility failed to ensure that an annual fire inspection by the Local Fire Authority (having jurisdiction) had been conducted. This deficient practice has the potential for all 124 (R #s 1-124) of (R #s 1-124) Residents identified on the resident census list provided by the Business Office Manager on 05/18/17, to be at risk of injury or death if a fire occurs. The findings are:<br><br>A. Record review for the annual fire inspection by the Local Fire Authority revealed that the last | A 060 | Corrective Action:<br>Corrective action for the personnel and residents who have the potential to be affected by the alleged deficient practice:<br>The annual fire inspection has been completed on 8/29/17.<br>Identification:<br>All residents have the potential to be affected by deficient practice.<br>Annual inspections scheduled.<br>Systematic Change:<br>Plant Operations audit in place to ensure inspections completed timely.<br>Audit will be reviewed monthly at Safety Committee.<br>Monitoring:<br>Executive Director, Plant Operations Director, or designee will audit inspections monthly to ensure completion.<br>ED, POD, or designee will review audits monthly at Safety Committee Meeting.<br>Audits will be reviewed quarterly at QA meetings. | 10/1/17 |

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| A 060 | Continued From page 57<br>inspection was conducted on 01/29/16 and was due 01/29/17.<br><br>B. On 05/18/17 at 10:45 am, during interview with the Maintenance Director (MD), he confirmed that the annual fire inspection by the Local Fire Authority was due on 01/29/17 and is almost four (4) months past due from time of survey. | A 060 | | |
| A 061 | 7 NMAC 8.2.61 Fire Alarms, Smoke Detectors and Other Equip<br><br>FIRE ALARMS, SMOKE DETECTORS AND OTHER EQUIPMENT:<br>A. Fire alarm system. Facilities with four (4) or more residents shall have a manual fire alarm system. The manual fire alarm shall be inspected and approved in writing by the fire authority with jurisdiction.<br>B. Smoke and heat detection. Approved smoke detectors shall be installed on each floor that when activated provides an alarm which is audible in all sleeping areas. Areas of assembly, such as the dining and living room(s) must also be provided with smoke detectors.<br>(1) Detectors shall be powered by the house electrical service and have battery back up.<br>(2) Construction of new facilities or facilities remodeling or replacing existing smoke detectors shall provide detectors in common living areas and in each sleeping room.<br>(3) Smoke detectors shall be installed in corridors at no more than thirty (30) foot spacing.<br>(4) Heat detectors shall be installed in all kitchens and also powered by the house electrical service.<br>[7.8.2.61 NMAC - Rp, 7.8.2.60 NMAC, 01/15/2010] | A 061 | A061<br>Corrective Action:<br>Fire panel has been replaced by Fire Alarm Company.<br><br>Fire panel will be checked by Plant Operations Director or designee monthly to ensure proper functioning.<br>Monthly audit for fire panel functioning put in place to ensure fire panel functioning.<br>Staff training on Emergency Procedures and Fire panel procedure completed by 9/6/17.<br>Identification: all residents are at risk for deficient practice.<br>Plant Operations Director or designee responsible<br>for Monthly audit for fire panel functioning to ensure fire panel functioning.<br>Systematic Change:<br>Newly hired staff will be trained on fire panel procedure at General Orientation.<br>Current staff trained on Fire panel procedure 10/17/17. | 10/17/17 |

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| A 061 | Continued From page 58<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.61 A<br><br>NFPA 72 (2010 Edition)<br>14.2.1.1 Performance Verification. To ensure operational integrity,<br>the system shall have an inspection, testing, and maintenance<br>program.<br>14.2.1.1.1 Inspection, testing, and maintenance programs<br>shall satisfy the requirements of this Code and conform to the<br>equipment manufacturer ' s published instructions.<br>14.2.1.1.2 Inspection, testing, and maintenance programs<br>shall verify correct operation of the system.<br>14.2.1.2 Impairments.<br>14.2.1.2.1 The requirements of Section 10.19 shall be applicable<br>when a system is impaired.<br>14.2.1.2.2 System defects and malfunctions shall be corrected.<br>14.2.1.2.3 If a defect or malfunction is not corrected at the<br>conclusion of system inspection, testing, or maintenance, the<br>system owner or the owner ' s designated representative shall<br>be informed of the impairment in writing within 24 hours.<br>14.2.2 Responsibilities.<br>14.2.2.1* The property or building or system owner or the<br>owner ' s designated representative shall be responsible for inspection,<br>testing, and maintenance of the system and for | A 061 | | |

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| A 061 | Continued From page 59 | A 061 | | |

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alterations
or additions to this system.
14.2.2.2 The delegation of responsibility shall be in writing,
with a copy of such delegation provided to the authority having
jurisdiction upon request.
14.2.2.3 Inspection, testing, or maintenance shall be permitted
to be done by the building or system owner or a person or
organization other than the building or system owner if conducted
under a written contract.

Based on observation and interview, the facility failed to ensure the fire alarm system was in good working order and not in trouble mode. If the fire alarm system is in trouble mode then it may not be reliable in notifying occupants and emergency response personnel of a potential fire in the building, placing all 124 (R #s 1-24) residents listed on the resident census list, provided by the Business Office Manager on 05/18/17 at risk harm, injury, or death if a fire were to occur. The findings are:

A. On 05/19/17 at 9:45 am, during an observation of the fire alarm panel on the 2nd floor of the Memory Care Unit (MCU), it was observed to read "trouble mode, priority 2". The observation was confirmed by DCS-M #4.

B. On 05/19/17 at 1:20 pm, during an observation of the fire alarm panel on the 1st floor of the MCU, it was observed to read "trouble mode, priority 2, and the smoke detector in the main corridor on the 4th floor dirty."

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| A 061 | Continued From page 60<br><br>C. On 05/19/17 at 1:21 pm, during interview with Medication Aide (MA) #2, she confirmed the observation that the fire alarm panel in the 1st floor MCU read that it was in "trouble mode, priority 2, smoke detector in main corridor on the 4th floor dirty".<br><br>D. On 05/19/17 at 2:30 pm, during an interview with the Maintenance Director (MD), he confirmed that he was aware that the fire alarm panel in the 1st floor MCU was in trouble mode and that the smoke detector on the 4th floor needed cleaning.<br><br>E. On 05/23/17 at 7:00 am, during an observation of the fire alarm system panel in the main entry way it was observed to read "trouble mode, sec-East-South stairwell exit door, PR12 alarm point abnormal."<br><br>F. On 05/23/17 at 8:04 am, during interview with the MD, stated that the alarm sensor on the South stairwell exit door does not always work correctly and that the fire alarm system was again in trouble mode. He also confirmed that the fire alarm system has been in trouble mode for different reasons from 05/19/17 thru 05/23/17. | A 061 | | |
| A 065 | 7 NMAC 8.2.65 Fire Drills<br><br>FIRE DRILLS: All facilities shall conduct monthly fire drills which are to be documented.<br>A. There shall be at least one (1) documented fire drill per month and at a minimum, one documented fire drill each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility.<br>B. A record of the monthly fire drills shall be maintained on file in the facility and readily | A 065 | | |

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| A 065 | Continued From page 61<br>available. Fire drill records shall show:<br>(1) the date of the drill;<br>(2) the time of the drill;<br>(3) the number of staff participating in the drill;<br>(4) any problem noted during the drill; and<br>(5) the evacuation time in total minutes.<br>C. If applicable, the local fire department may be requested to supervise and participate in fire drills.<br>[7.8.2.65 NMAC - Rp, 7.8.2.65 NMAC, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.65 A<br><br>Based on record review and interview, the facility failed to conduct and document fire drills each eight (8) hours (day, evening, night) per quarter that employs the use of the fire alarm system or the detector system in the facility. This deficient practice has the potential to cause harm or death to all 124 (R #s 1-124) of (R #s 1-124) residents identified on the resident census list provided by the Business Office Manager on 05/18/17, if staff and residents are not prepared/trained on what to do in the event of a fire or emergency. The findings are:<br><br>A. Record review of the facility's fire drill record book, revealed there was no documentation of a fire drill being conducted during the months of February and March 2017.<br><br>B. On 05/17/17 at 3:15 pm, during interview with the Maintenance Director (MD), he confirmed that the facility did not conduct a fire drill during the months of February and March, 2017. | A 065 | A065<br>Corrective Action:<br><br>Fire drills will be completed 1 per month per 8 hour shift.<br>Plant Operations Director or designee will complete Monthly audit for fire drills to ensure fire drill completion.<br>Staff training on Emergency Procedures and Fire Drills completed by 9/6/17.<br>Identification: all residents are at risk for deficient practice.<br>Plant Operations Director or designee responsible for Monthly audit for fire drills to ensure fire drill completion.<br>Systematic Change:<br>Newly hired staff will be trained on fire drill completion at General Orientation.<br>Current staff trained on Fire drills by 9/6/17. | 10/1/17 |

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| A 068 | 7 NMAC 8.2.68 Hospice<br><br>HOSPICE: An assisted living facility that provides or coordinates hospice care and services shall meet the requirements in this section, in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC.<br>A. Definitions: in addition to the requirements for all assisted living facilities pursuant to " DEFINITIONS, " 7.8.2.7 NMAC, the following definitions shall also apply.<br>(1) " Hospice agency " means an organization, company, for-profit or non-profit corporation or any other entity which provides a coordinated program of palliative and supportive services for physical, psychological, social and the option of spiritual care of terminally ill people and their families. The services are provided by a medically directed interdisciplinary team in the person's home and the agency is required to be licensed pursuant to 7.12 NMAC.<br>(2) " Hospice care " means a focus on palliative, rather than curative care. The goal of the plan of care is to help the patient live as comfortably as possible, with emphasis on eliminating or decreasing pain and other uncomfortable symptoms.<br>(3) " Licensed assisted living provider " means a facility that provides twenty-four (24) hour assisted living and is licensed by the department of health.<br>(4) " Hospice services " means a program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members.<br>(5) " Care coordination requirements " means a written document that outlines the care and services to be provided by the hospice agency for assisted living residents that require hospice | A 068 | A068 B<br>At General Orientation, newly hired staff will be trained on Hospice and Palliative Care.<br>Current Staff will receive State required 6 hours of Palliative and Hospice Care annual training by 10/31/17.<br><br>Identification:<br>A068B<br>Business Office Manager has Completed an audit of all staff records regarding completion of 6 hours of State required annual Hospice trainings.<br>Any staff who have not completed 6 hours of annual Hospice trainings given notice to complete by 10/31/17.<br>If trainings have not been completed by 10/31/17<br>staff will be removed from schedule until completed. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2258 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______ | (X3) DATE SURVEY COMPLETED C 05/23/2017 |
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| **THE WOODMARK AT UPTOWN** | **7201 PROSPECT PLACE NE ALBUQUERQUE, NM 87110** |

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| A 068 | Continued From page 63<br>services.<br>(6) " Palliative care " means a form of medical care or treatment that is intended to reduce the severity of disease symptoms, rather than to reverse progression of the disease itself or provide a cure.<br>(7) " Terminally ill " means a diagnosis by a physician for a patient with a prognosis of six (6) months or less to live.<br>(8) " Visit notes " means the documentation of the services provided for hospice residents and includes ongoing care coordination.<br>B. Employee training and support. A facility that provides hospice services shall provide the following education and training for employees who assist with providing these services:<br>(1) provide a minimum of six (6) hours per year of palliative/hospice care training, which includes one (1) hour specific to the hospice resident ' s ISP, in addition to the basic staff education requirements pursuant to 7.8.2.17 NMAC; and<br>(2) offer an ongoing employee psychological support program for end of life care issues.<br>C. Individual service plan (ISP) requirements.<br>(1) Each resident who receives hospice services shall be provided the necessary palliative care to meet the individual resident ' s needs as outlined in the ISP and shall include one (1) hour of training specific to the resident for all direct care staff.<br>(2) The assisted living facility, in coordination with the hospice provider, shall create an ISP that identifies how the resident's needs are met and includes the following:<br>(a) the requirements set forth in the " Individual Service Plan, " 7.8.2.26 NMAC, and " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC;<br>(b) what services are to be provided; | A 068 | A<br>Monitoring:<br>A068 B<br>The Executive Director, BOM, Department Director or designee will be responsible for ensuring that the 6 hours State required annual Hospice training is completed.<br>Executive Director, Business Office Manager, or designee will be responsible for monthly audit of 6 hours State required Annual Hospice training.<br>Results of audits will be reviewed at quarterly QA meetings. | 10/31/17 |

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| A 068 | Continued From page 64<br>(c) who will provide the services;<br>(d) how the services will be provided;<br>(e) a delineation of the role(s) of the hospice provider and the assisted living facility in the ISP process;<br>(f) documentation (visit notes) of the care and services that are provided with the signature of the person who provided the care and services; and<br>(g) a list of the current medications or biologicals that the resident receives and who is authorized to administer them.<br>(3) Medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals:<br>(a) a physician;<br>(b) a physician extender (PA or NP);<br>(c) a licensed nurse (RN or LPN);<br>(d) the resident if their PCP has approved it;<br>(e) family or family designee; and<br>(f) any other individual in accordance with applicable state and local laws.<br>D. Care coordination.<br>(1) The assisted living facility shall be knowledgeable with regard to the hospice requirements pursuant to 7.12 NMAC and ensure that the hospice agency is well informed with regard to the assisted living provisions pursuant to Subsection C of 7.8.2.20 NMAC.<br>(2) The assisted living facility shall hold a team meeting prior to accepting or retaining a hospice resident in accordance with " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC.<br>(3) Upon admission of a resident into hospice care, the assisted living facility shall designate a section of the resident ' s record for hospice | A 068 | | |

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| A 068 | Continued From page 65<br>documentation.<br>(a) The facility shall provide individual records for each resident.<br>(b) The hospice agency shall leave documentation at the facility in the designated section of the resident ' s record.<br>(4) The assisted living facility shall provide the resident and family or surrogate decision maker with information on palliative care and shall support the resident ' s freedom of choice with regard to decisions.<br>(5) Hospice services shall be available twenty-four (24) hours a day, seven (7) days a week for hospice residents, families and facility staff and may include continuous nursing care for hospice residents as needed. These services shall be delivered in accordance with the resident ' s individual service plan (ISP) and pursuant to 7.8.2 26 NMAC.<br>(6) The assisted living facility shall ensure the coordination of services with the hospice agency.<br>(a) The resident's individual service plan (ISP) shall be updated with significant changes in the resident ' s condition and care needs.<br>(b) The assisted living facility shall receive information and communication from the hospice staff at each visit.<br>(i) The information shall include the resident status and any changes in the ISP (i.e., medication changes, etc.).<br>(ii) The information shall be in the form of a verbal report to the assisted living facility staff and also in the form of written documentation.<br>(c) The assisted living facility or the family/resident shall reserve the right to schedule care conferences as the needs of the resident and family dictate. The care conferences shall include all care team members.<br>(d) Concerns that arise with regard to the delivery | A 068 | | |

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| A 068 | Continued From page 66<br>of services from either the assisted living facility or the hospice agency shall first be addressed with the facility administrator and the hospice agency administrator.<br>(i) The process may be informal or formal depending on the nature of the issue.<br>(ii) If an issue can not be resolved or if there is an immediate danger to the resident the appropriate authority shall be notified.<br>E. Additional provisions. An assisted living facility that provides or coordinates hospice care and services shall make additional provisions for the following requirements:<br>(1) individual services and care: each resident receiving hospice services shall be provided the necessary palliative procedures to meet individual needs as defined in the ISP;<br>(2) private visiting space:<br>(a) physical space for private family visits;<br>(b) accommodations for family members to remain with the patient throughout the night; and<br>(c) accommodations for family privacy after a resident ' s death.<br>F. Medicare and medicaid restrictions. Assisted living facilities shall not accept a resident considered " hospice general inpatient " which would be billable to medicare or medicaid because the facility will not qualify for payment by medicare or medicaid.<br>[7.8.2.68 NMAC - N, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.68 B (1), C (2)<br><br>Based on record review and interview the facility failed to ensure that:<br>1. Direct Care Staff (DCS) received an additional 6 hours of hospice specific training | A 068 | | |

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| A 068 | Continued From page 67<br>annually;<br>2. Individual Service Plans (ISPs) include documentation of coordination of care with the hospice provider.<br><br>These deficient practices have the potential for the 2 (R #s 3 & 4) of 17 (R #s 1-17) Residents identified as receiving hospice services by the Business Office Manager (BOM) on 05/18/17 to be at risk of:<br>1. Not receiving the individual end of life care and services needed if they elect to receive hospice benefits from an outside provider, if the staff have not received/completed the additional 6-hours of annual hospice specific training.<br>2. Not receiving needed care/services if staff are not aware of what care/services they are to provide and what care/services will be provided by the hospice agency. The findings are:<br><br>Findings related to hospice training<br><br>A. Record review of DCS #s 1-3 staff files revealed no documentation that DCS #s 1-3 received the additional six (6) hours of annual hospice training.<br><br>B. On 05/23/17 at 9:45, during interview with the BOM, she confirmed that the facility could not provide documentation or confirm that DCS #s 1-3 had received the required six (6) hours of annual hospice training.<br><br>Findings related to ISP's<br><br>C. Record review of R #3's ISP dated 12/05/16, revealed no documentation of coordination of care with her hospice provider.<br><br>D. Record review of R #4's ISP dated 05/08/17, | A 068 | | |

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| A 068 | Continued From page 68<br>revealed no documentation of coordination of care with her hospice provider.<br><br>E. On 05/19/17 at 11:45 am, during interview with the Director of Memory Care, she confirmed that the ISPs for R #s 3 and 4 had not been updated to include documentation of coordination of care with their hospice provider. | A 068 | A069<br>At General Orientation, newly hired staff will be given training on Alzheimers & Dementia.<br>Current Staff will receive 12 hours of State required Alzheimer's & Dementia training annually by 10/31/17. | |
| A 069 | 7 NMAC 8.2.69 Memory Care Units<br><br>MEMORY CARE UNITS: An assisted living facility that provides a memory care unit to serve residents with dementia shall comply with the provisions of subsection A-J below in addition to the rules applicable to all assisted living facilities, 7.8.2 NMAC.<br>A. Additional definitions: The following definitions, in addition to those in 7.8.2.7 NMAC, shall apply.<br>(1) " Alzheimer ' s " means a brain disorder that destroys brain cells, causing problems with memory, thinking and behavior that are severe enough to affect work, lifelong hobbies or social life. Alzheimer ' s gets progressively worse and is fatal.<br>(2) " Care coordination agreement requirement " means a written document that outlines the care and services that are provided by other outside agencies for assisted living residents that require additional care and services.<br>(3) " Dementia " means loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain.<br>(4) " Memory care unit " means an assisted living facility or part of or an assisted living facility that provides added security, enhanced programming and staffing appropriate for residents with a diagnosis of dementia, Alzheimer | A 069 | Identification:<br>A069<br>Business Office Manager has Completed an audit of all staff records regarding completion of State required 12 hours of annual Alzheimer's & Dementia trainings.<br><br>Business Office Manager will complete monthly audit of staff records regarding completion of state required 12 hours of Alzheimer's & Dementia training. | |

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| A 069 | Continued From page 69<br>' s disease or other related disorders causing memory impairments and for residents whose functional needs require a specialized program.<br>(5) " Secured environment " means locked (secured/monitored) doors/fences that restrict access to the public way for residents who require a secure unit.<br>B. Care coordination requirement. An assisted living facility that accepts residents with memory issues shall determine which additional services and care requirements are relevant to the resident and disease process.<br>(1) The medical diagnosis and ISP shall be utilized in the determination of the need for additional services.<br>(2) The assisted living facility shall ensure the coordination of services and shall have evidence of an agreement of care coordination for all services provided in the facility by an outside health care provider.<br>C. Employee training. In addition to the training requirements for all assisted living facilities, pursuant to 7.8.2.17 NMAC, all employees assisting in providing care for memory unit residents shall have a minimum of twelve (12) hours of training per year related to dementia, Alzheimer ' s disease, or other pertinent information.<br>D. Individual service plan (ISP). An assisted living facility that admits memory care unit residents shall create an ISP in coordination with the resident ' s primary care practitioner, in compliance with the requirements outlined in " Individual Service Plan, " 7.8.2.26 NMAC, pursuant to a team meeting as described in " Exceptions to admission, readmission and retention, " Subsection C of 7.8.2.20 NMAC, and which ensures the following criteria:<br>(1) identification of the resident's needs specific | A 069 | Monitoring:<br>A069<br><br>The Executive Director, Business Office Manager, Department Director or designee will be responsible for ensuring that the 12 hours State required Alzheimer's & Dementia annual training is completed.<br><br>Executive Director, Business Office Manager, or designee will be responsible for monthly audit of 12 hours State required Annual Alzheimer's and Dementia training. Results of audits will be reviewed at quarterly QA meetings.<br><br>Results of audits will be reviewed at QA meeting quarterly. | 10/31/17 |

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| A 069 | Continued From page 70<br>to the memory care unit and the services that are provided; each memory unit resident shall receive the services necessary to meet the individual resident ' s needs;<br>(2) medications shall be self-administered, self-administered with assistance by an individual that has completed a state approved program in medication assistance or administered by the following individuals:<br>(a) a physician;<br>(b) a physician extender (PA or NP);<br>(c) a licensed nurse (RN or LPN);<br>(d) the resident if their PCP has approved it;<br>(e) family or family designee; and<br>(f) any other individual in accordance with applicable state and local laws.<br>E. Assessments and reevaluations.<br>(1) An assessment shall be completed by a registered nurse or a physician extender within fifteen (15) days prior to admission. When emergency placement is warranted the fifteen (15) day assessment shall be waived and the assessment shall be completed within five (5) days after admission.<br>(a) The resident shall have a medical evaluation and documentation by a physician, physician's assistant or a nurse practitioner within six (6) months of admission.<br>(b) The pre-admission assessment shall include written findings, an evaluation of less restrictive alternatives and the basis for the admission to the secured environment. The written documentation shall include a diagnosis from the resident's PCP of Alzheimer's disease or other dementia and the need for the resident to reside in a memory care unit.<br>(c) Only those residents who require a secured environment placement or whose needs can be met by the facility, as determined by the | A 069 | | |

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| A 069 | Continued From page 71<br>assessment prior to admission or on review of the individual service plan (ISP), shall be admitted.<br>(2) A re-evaluation must be completed every six (6) months and when there is a significant change in the medical or physical condition of the resident that warrants intervention or different care needs, or when the resident becomes a danger to self or others, to determine whether the resident ' s stay in the assisted living facility memory care unit is still appropriate.<br>F. Documentation in the resident ' s record. In addition to the required documentation pursuant to 7.8.2.21 NMAC, the following information shall be documented in the resident ' s record:<br>(1) the physician ' s diagnosis for admission to a secure environment or a memory care unit;<br>(2) the pre-admission assessment; and<br>(3) the re-evaluation(s).<br>G. Secured environment.<br>(1) Memory care unit residents may require a secure environment for their safety. A secured environment is any locked (secured/monitored) area in which doors and fences restrict access to the public way. These include but are not limited to:<br>(a) double alarm systems;<br>(b) gates connected to the fire alarm; and<br>(c) tab alarms for residents at risk for elopement.<br>(2) In addition to the interior common areas required by this rule, the facility shall provide a safe and secure outdoor area for the year round use by the residents.<br>(a) Fencing or other enclosures shall prevent elopement and protect the safety and security of the residents.<br>(b) Residents shall be able to independently access the outdoor areas.<br>(3) Locked areas shall have an access code or | A 069 | | |

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| A 069 | Continued From page 72<br>key which facility employees shall have available on their person or on the locking unit itself at all times.<br>H. Resident rights. In addition to the requirements pursuant to 7.8.2.32 NMAC, the following shall apply:<br>(1) the resident's rights may be limited as required by their condition and as identified in the ISP;<br>(2) the resident who believes that he or she has been inappropriately admitted to the secured environment may request the facility in contact the resident ' s legal guardian, or an advocate such as the ombudsman or the primary care practitioner; upon request, the facility shall assist the resident in making such contact.<br>I. Disclosure to residents. A facility that operates a secured environment shall disclose to the resident and the resident ' s legal representative, if applicable and prior to the resident ' s admission to the facility, that the facility operates a secured environment.<br>(1) The disclosure shall include information about the types of resident diagnosis or behaviors that the facility provides services for and for which the staff are trained to provide care for.<br>(2) The disclosure shall include information about the care, services and the type of secured environment that the facility and trained staff provide.<br>J. Staffing. The facility shall provide the sufficient number of trained staff members to meet the additional needs of the residents in the secured environment. There must be at least one (1) trained staff member awake and in attendance in the secured environment at all times.<br>[7.8.2.69 NMAC - N, 01/15/2010] | A 069 | | |

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| A 069 | Continued From page 73<br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.69 C<br><br>Based on record review and interview, the facility failed to ensure that 3 (DCS #s 1-3) of 3 (DCS #s 1-3) Direct Care Staff had completed the additional twelve (12) hours of annual dementia specific training. This deficient practice has the potential for residents with dementia to be at risk of not receiving the specialized individual (physical, mental, social) care and services that residents with Dementia (a decline in memory or other thinking skills) require because the DCS have not completed the required annual dementia training. The findings are:<br><br>A. Record review of DCS #s 1-3 staff files revealed no documentation that DCS #s 1-3 received the additional twelve (12) hours of annual dementia training.<br><br>B. On 05/23/17 at 9:48 am, during interview with the Business Office Manager, she confirmed that the facility could not provide documentation or confirm that DCS #s 1-3 had received the required twelve (12) hours of annual dementia training. | A 069 | | |
| A 070 | 7 NMAC 8.2.70 Incorporated and Related Rules and Codes<br><br>INCORPORATED AND RELATED RULES AND CODES: The facilities that are subject to this rule are also subject to other rules, codes and standards that may, from time to time, be amended. This includes the following:<br>A. Health Facility Licensure Fees and Procedures, New Mexico Department of Health, | A 070 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 2258 | A. BUILDING: ____ B. WING ____ | C 05/23/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE WOODMARK AT UPTOWN | 7201 PROSPECT PLACE NE ALBUQUERQUE, NM 87110 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| A 070 | Continued From page 74<br>7.1.7 NMAC.<br>B. Health Facility Sanctions and Civil Monetary Penalties, New Mexico Department of Health, 7.1.8 NMAC.<br>C. Adjudicatory Hearings for Licensed Facilities, New Mexico Department of Health, 7.1.2 NMAC.<br>D. Caregiver's Criminal History Screening Requirements, 7.1.9 NMAC.<br>E. Employee Abuse Registry 7.1.12 NMAC.<br>F. Incident Reporting, Intake Processing and Training Requirements 7.1.13 NMAC.<br>[7.8.2.70 NMAC - N, 01/15/2010]<br><br>This REQUIREMENT is not met as evidenced by:<br>7.8.2.70 F<br><br>7.1.13 INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS<br><br>Refer to 7.1.13.7 W. & 8 B. (2)<br><br>W. "Reportable incident" means possible abuse, neglect, exploitation, injuries of unknown origin and other events including but not limited to falls which cause injury, unexpected death, elopement, medication error which causes or is likely to cause harm, failure to follow a doctor's order or an ISP, or any other incident which may evidence abuse, neglect, or exploitation.<br><br>B. (2) Division incident report form and notification by licensed health care facilities: The licensed health care facility shall report incidents utilizing the division's incident report form consistent with the requirements of the division's | A 070 | A070<br>Corrective Action: Corrective action for the personnel who have the potential to be affected by the alleged deficient practice:<br>Company incident reporting policy and procedure revised 6/8/17. Community staff trained on updated community policy and procedure for incident reporting to the Licensing Authority within 24 hours or next business day if holiday or weekend by 9/15/17.<br>HWD will provide licensed staff training regarding the emergency procedures and incident policy & procedure and notification of Licensing Authority within 24 hours or next business day if on holiday or weekend by 10/15/17.<br>Weekly resident review with ED, HWD, RCC and MCD to ensure oversight and review ongoing changes.<br>Executive Director to hold Staff training 10/17/17 to review policy and procedure for incident reporting to the State Licensing Authority utilizing division's incident report form.<br>Identification:<br>Community staff and all residents have the potential to be affected by this deficient practice. | |

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| A 070 | Continued From page 75<br>incident management system guide and CMS regulations as applicable. The licensed health care facility shall ensure that all incident report forms alleging abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents are submitted by a reporter with direct knowledge of an incident, are completed on the bureau's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The licensed health care facility shall ensure that the reporter with the most direct knowledge of the incident assists with the preparation of the incident report form<br><br>Based on record review and interview, the facility failed to ensure for 4 (R #s 1, 5, 7 and 9) of 5 (R #s 1, 2, 5, 7, and 9) residents whose internal incident reports were reviewed for compliance were reported to the Licensing Authority within twenty-four (24) hours or by the next business day if it is a weekend or a holiday. If the facility is not reporting incidents to the Licensing Authority then there would be no oversite to protect the residents from being abused, neglected, and/or injured. The findings are:<br><br>Findings related to R #1<br>A. Record review of the facility's Incident Report Book revealed no documentation that R #1's unwitnessed fall with injuries to her head (requiring stitches), bruises to her arms and thighs on 05/01/17 was reported to the Licensing Authority.<br><br>B. On 05/22/17 at 3:11 pm, during interview with Registered Nurse (RN #1), she confirmed that the facility did not report R #1's unwitnessed fall with injuries to the Licensing Authority. She further | A 070 | HWD will provide licensed staff training regarding the emergency procedures and incident policy & procedure and notification of Licensing Authority utilizing the division report form within 24 hours or next business day if on holiday or weekend by 10/16/17.<br>Weekly resident review with ED, HWD, RCC and MCD to ensure oversight and review ongoing changes.<br>Executive Director to hold Staff training 10/17/17 to review policy and procedure for incident reporting to the State Licensing Authority utilizing division reporting form.<br>Identification:<br>Community staff and all residents have the potential to be affected by this deficient practice.<br>Systematic Change:<br>Newly hired staff will be trained on policy and procedure for Incident Reporting to the State Licensing Authority utilizing division reporting form at General Orientation. Staff will be trained on Incident reporting to the Licensing Authority utilizing division reporting form in annual training. | |

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| A 070 | Continued From page 76<br>stated that to her knowledge in the 4-1/2 years she has been at the facility they have never reported falls to the Licensing Authority.<br><br>Findings related to R #5<br><br>C. Record review of the nurses note for R #5 dated 03/03/17, revealed that R #5 was sitting on the toilet and fell face first, while the Direct Care Staff (DCS) had turned to retrieve the resident's clothing from the bed, the DCS was not able to get back in time to catch her. R #5 was unconscious for a time and required Emergency Medical Services (EMS). R #5's Electrocardiogram (EKG) (heart monitoring test) revealed a heart anomaly (unusual) and she was taken to the Emergency Room (ER).<br><br>D. Record review of the facility incident report for R #5 dated 03/03/17, that there was no documentation that R #5's fall, being unconscious, and requiring Emergency Medical Services (EMS), then being transported/admitted to the hospital was reported to the Licensing Authority.<br><br>E. On 05/22/17 at 11:05 am, during interview with RN #1, she confirmed that R #5's fall with injuries/unconsciousness requiring EMS services and hospitalization was not reported to the state. R #1 stated that in the 4 1/2 years she has been working at the facility she has only seen the State Incident Report form used once and that was since the current Administrator arrived.<br><br>Findings for R #9<br><br>E. Record review of the facility's incident report for R #9 dated 04/09/17, revealed that she was given R #11's medications (including medication | A 070 | Current staff will be trained on policy and procedures for proper notification to Licensing authority utilizing division reporting form on 10/17/17.<br>Monitoring<br>Executive Director, Business Office Manager, or designee will be responsible for monthly audit of General Orientation completion, Annual training attendance and ongoing staff training, community documents. Review of audits and corrections will be discussed at QA quarterly.<br><br>HWD, RCC, LN or designee will complete Quarterly audit of 10% of resident charts to ensure accuracy Results of audits will be shared at QA meetings quarterly. | 10/17/17 |

Division of Health Improvement

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| A 070 | Continued From page 77<br>for hypertension/High Blood Pressure) after she was given her own medications. There is no documentation on the report that the medication error which had the potential for harm was reported to the Licensing Authority.<br><br>F. On 05/23/17 at 8:48 am, during interview with the Director of Memory Care (DMC), she confirmed that the medication error for R #9 was not reported to the Licensing Authority and stated she was not aware that medication errors had to be reported.<br><br>Findings related to R #7<br><br>G. Record review of R #7's Assisted Living & Memory Care Incident/Occurrence report dated 12/16/16 completed by Medication Aide (MA #1) revealed, that the resident had an unwitnessed fall and was complaining of a pain in left wrist, was not reported to the Licensing Authority.<br><br>H. On 05/23/17 at 10:35 am during an interview with the Administrator, she confirmed that R #7's unwitnessed fall on 12/16/16, where resident was complaining of pain in left wrist, was not reported to the Licensing Authority.<br><br>I. On 05/23/17 at 11:30 am, during interview with the Administrator, she confirmed that the reportable incidents for R #s 1, 5, 7, and 9 were not reported the Licensing Authority within 24 hours or the next business day if a weekend or holiday. | A 070 | | |